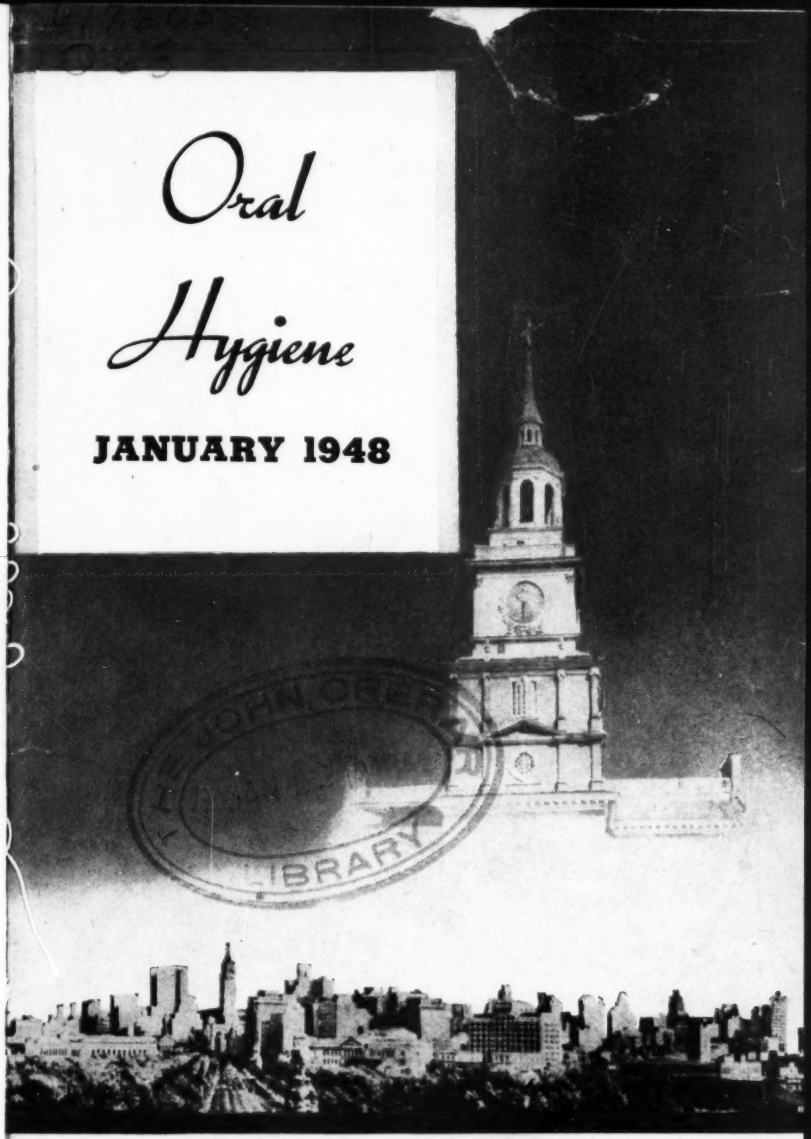
Oral Hygiene

JANUARY 1948



Greater Philadelphia Dental Society Meeting, February 4-6

In This Issue:

OFFICE MODERNIZATION AND INCOME TAXES

COMPLETE TABLE OF CONTENTS, PAGE 31

ADD to your patient's comfort
SUBTRACT from your own fatigue

Nine times out of ten a patient will tell you what he dreads most is the operation of the handpiece, though he may call it "drilling" or "grinding."

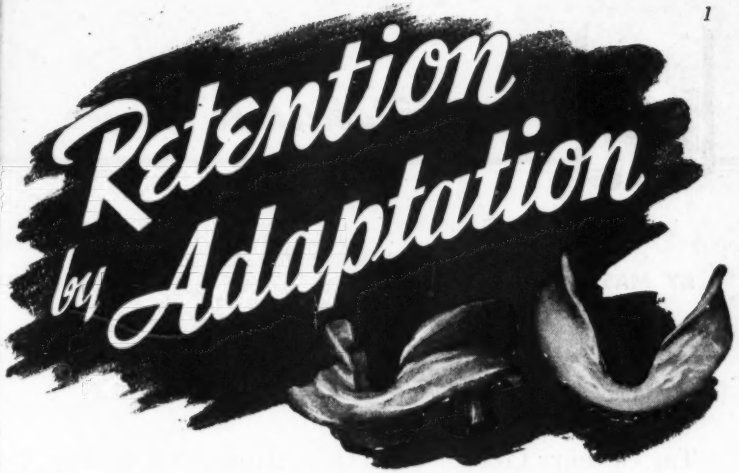
When a *SANI-TERRY* Handpiece is used there is much less discomfort for the patient and less fatigue for the dentist. A new *SANI-TERRY* Handpiece is true-running, smooth in operation and free from unnecessary vibration. It retains these qualities because of its unusual resistance to wear. Work proceeds more rapidly because of the patient's freedom from strain.

There is no backward drag on operator's wrist since the weight is balanced at the point where the handpiece is naturally grasped.

CLEV-DENT CONTRA-ANGLE U

If preferred, Clev-Dent Contra-Angle U may be used with the Sani-Terry Handpiece. It fits accurately over the handpiece and is free from unnecessary vibration.

Retention by Adaptation



There is no doubt that the case illustrated above would be a major problem to any dentist. As you can see, the mandible is concave from pad to pad and is covered with thick layers of soft, movable tissues.

FLOWS WITHOUT PRESSURE

NO TISSUE DEHYDRATION

FIRM SET

NO DISTORTION

It would be impossible to make a successful denture for this mouth from an impression taken under pressure. The only chance for success is to obtain retention by perfect adaptation.

Free flowing Konformax Full Mouth Impression Material was placed in an oversize, under-extended baseplate tray. A closed mouth impression was taken. The material flowed without pressure leaving the tissues in normal position . . . thus perfect adaptation was obtained!

Needless to say, since Konformax Full Mouth Impression Material solved this extreme denture problem, it certainly should be the material for all your full denture work.

The name of this patient (a dentist), who has been wearing this successful denture for 3 years, will be given on request.

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The Publisher's Corner

BY MASS **NUMBER 319**

FROM THE MAIL BAG

THE OCTOBER CORNER, about ORAL HYGIENE's first editor, Doctor George Edwin Hunt, prompted a letter from an old friend, a California member of the profession, Doctor Harry Tuckey.

He wrote: "Your October CORNER about George Edwin Hunt's 1911 editorial excoriating Doctor William Hunter's address (in Montreal at McGill University in October of 1910) interested me very much. I have read the address many times." In 1911, he remembers, most of the dental editors of that day "did their best to disqualify this great man of medicine. Whether anyone likes it or not, it is still one of the greatest masterpieces of medico-dental literature."

In Harry's opinion, "it could be reprinted today, instead of being left buried on a dusty shelf with the other bound volumes of the London *Lancet*. It appeared in the January, 1911, issue."

As recalled in the October column, Doctor Hunter had conceded that American dentists were mechanical geniuses, but, in his opinion, they didn't know anything about sepsis and were in the habit of "building a veritable mausoleum of gold over a mass of sepsis." Actually, George Edwin tempered his editorial by admitting, in print, that Doctor Hunter's denunciation had "a basis in truth," and said he thought it a pity that the

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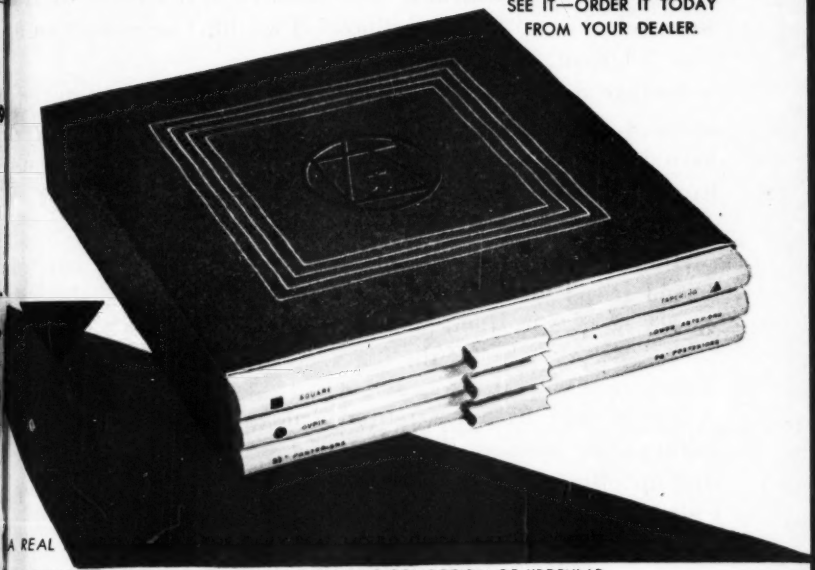

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YOU DON'T HAVE TO PRACTICE WITHOUT A MOULD GUIDE

British physician "should not have had the opportunity to se some really good American dentistry." Because I wasn't aroun here in those days, I never did see a copy of the famous address, and I haven't come upon it since then. Even if I had—or if I were to look it up and read it now—I wouldn't be competent to pass judgment.

Neither did I ever read other dental magazine editorials about it. From what my California friend writes, they must have raised more ned than George Edwin did. There must have been no end of an uproar. Perhaps the memory of it is still vivid in the minds of other CORNER readers.

At any rate, this department's October reference to it spurred an old friend to write a welcome letter, the first from him in years.

* * *

Another old friend, a retired dentist, writes: "Here's my picture at the moment. I'm sitting in a big, old-fashioned super-cozy upholstered rocker. There's a small table at my right elbow with tobacco, pipes, and books on it. Also at my right, within reach, is a large radio. To my left, a small table holds my typewriter (now in my lap), along with scrapbooks and writing paper. Near my right knee, there's another little table where I keep the Thesaurus, the dictionary, and such.

"Four feet away from my tootsies is a gas stove. And all I have to do tomorrow is to go down to the savings bank and pluck a fat plum off the tree I planted some years ago."

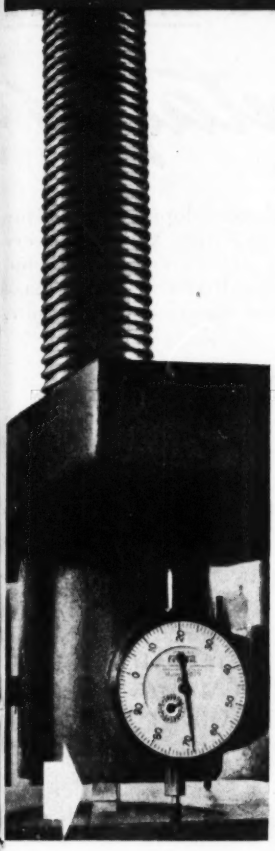
Ah me.

* * *

Recent CORNERS about "Your Best Years" brought several letters, some of which have already been quoted and unquoted. Here's another, from an old friend who says, in effect, "fooey on retiring." He's starting his eighty-seventh year "on this fine

(*Continued on page* 10)

strength *under stress*



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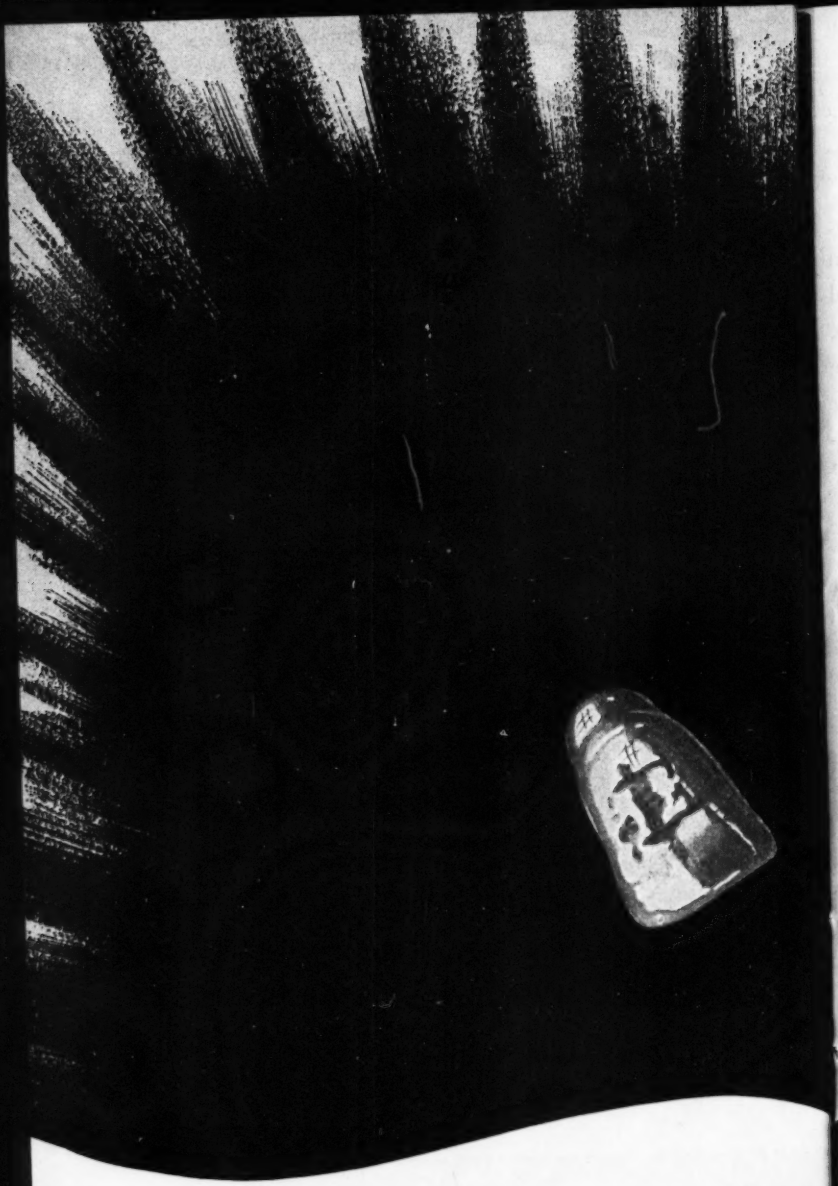

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(*Continued from page* 4)

globe," and is "still in the ring, still practicing dentistry." He adds: "Of course, I pick my cases—do what I like best to do."

His physical activity isn't confined to dentistry, either. Listen: "These fellows who think they're old at fifty should have seen me a while ago. I was up on the roof of our house, sawing and cutting away branches that had come down in a big windstorm, and throwing them on the ground. Some days later, I sawed the branches into firewood for the winter. Now, I have enough for our two fireplaces to last for a couple of years." This eighty-seven-year-old friend of the magazine signs himself "Junior."

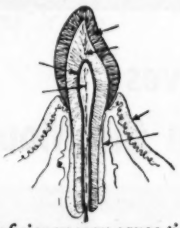
* * *

Does any customer of this nook know about the song called "The Handsome Young Dentist in Room 17"? A while ago, it was mentioned in E. V. Durling's Hearst newspaper column, "On the Side." Durling wrote that Dorothy Ross, a night-spot entertainer, "a gay singer of mischievous songs, is still rendering this quaint ditty."

* * *

Helen MacDonald Webster, a California friend, sends a compilation of "Odd Facts and Fancies About Teeth." One or two will be tucked into these pages now and then. Here's a sample: "Did you know that mothers in remote areas in Russia sometimes tie the body of a small toad around the neck of a young child —to preserve and strengthen the teeth?" These Russians! Another did-you-know-that: "Mongolian Chinese believe that extracted teeth, ground fine and added to the evening rice, promote sound sleep and a hearty breakfast appetite."

Citrus fruits help build teeth "hard and fast"!



C deficiency may cause tissue degeneration in enamel, cement, dentine, odontoblasts, pulp, and gingiva.

The role of nutrition—particularly of vitamin C—in tooth health and development is receiving increasing emphasis.[3] Dietary deficiencies of ascorbic acid are the reported etiology in many cases of dental osteoporosis, pulp necrosis, pyorrhea alveolaris and gingivitis.[2] And in the growing tooth, interference with dentine, enamel and cementum formation have been demonstrated,[1] with marked alterations of odontoblasts and liquescence of dentine[3] under C deficiencies. Indeed, the preponderance of clinical data today indicates that the soundness of the teeth and their supporting structures is "importantly dependent upon the amount of vitamin C supplied by the food"[4]—and there is no more effective or satisfying way for your patients to meet this vital need than by the routine inclusion of ample quantities of Florida citrus fruits* and juices—either fresh or canned—in their daily diet.

REFERENCES:

1. Boyle, P.E. et al: Proc. Soc. Exp. Biol. & Med., 36:773, 1937.
2. Bridges, M.A.: Dietetics For The Clinician, Lea & Febiger, Phila., 4th ed., 1941.
3. Rose, M.S.: Rose's Foundation of Nutrition, revised by G MacLeod and C M. Taylor, Macmillan Co., New York, 4th ed., 1944.
4. Sherman, H.C.: Chemistry of Food and Nutrition, Macmillan Co., New York, 7th ed., 1946.

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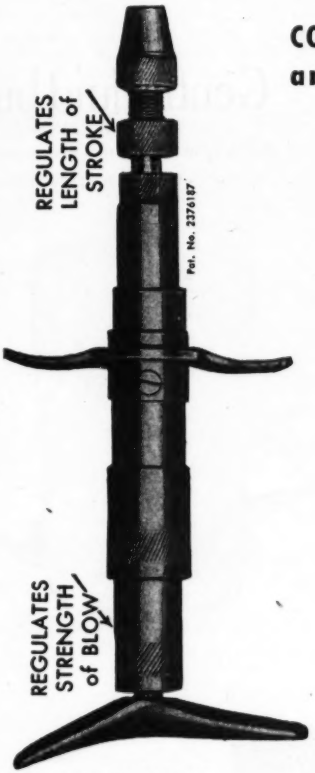

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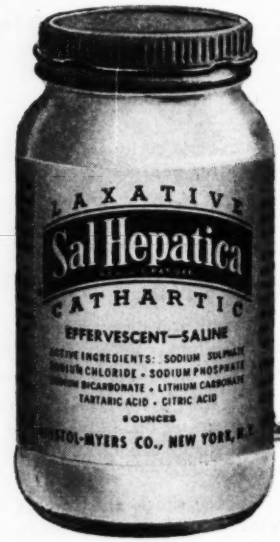

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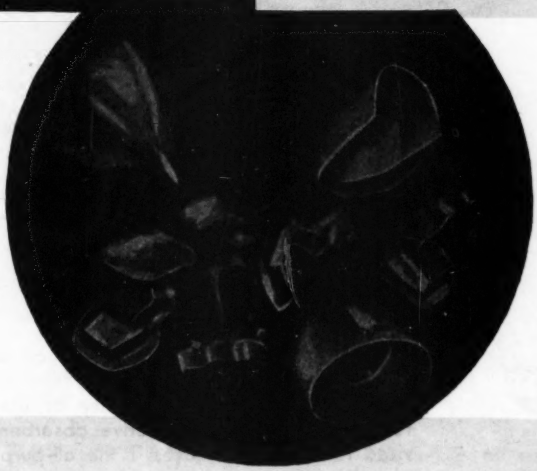

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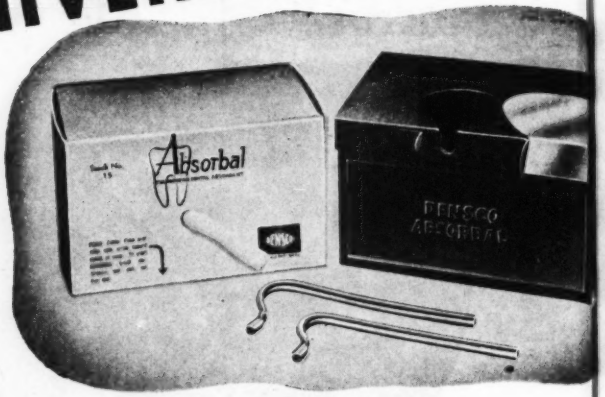

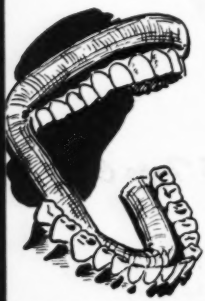

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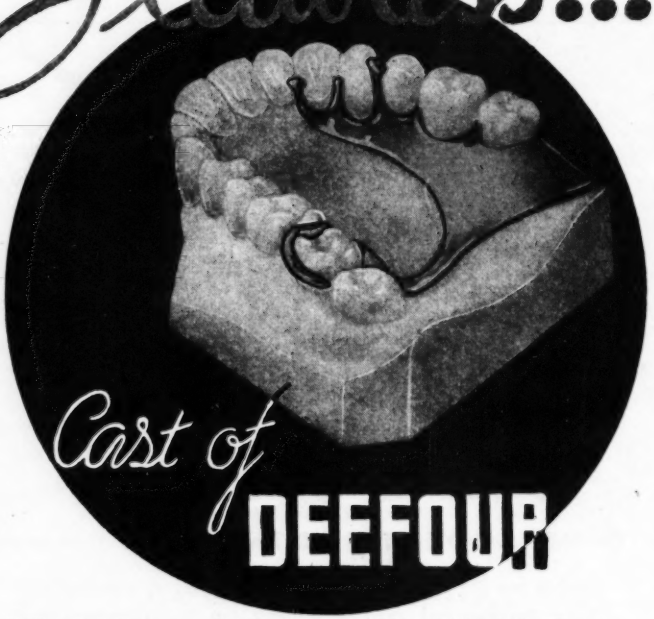

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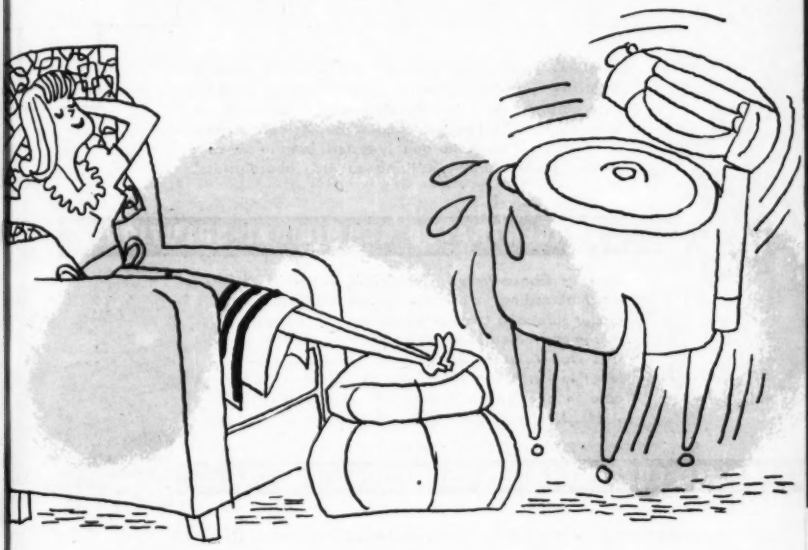

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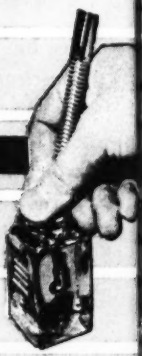

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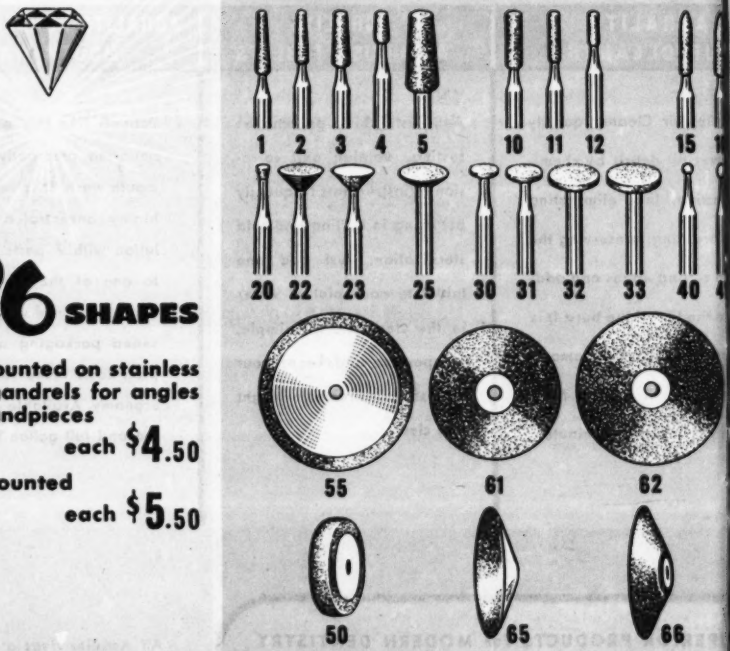

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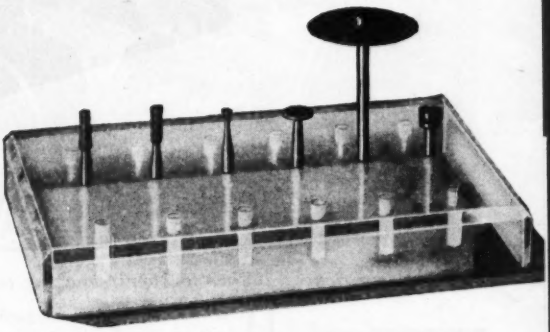

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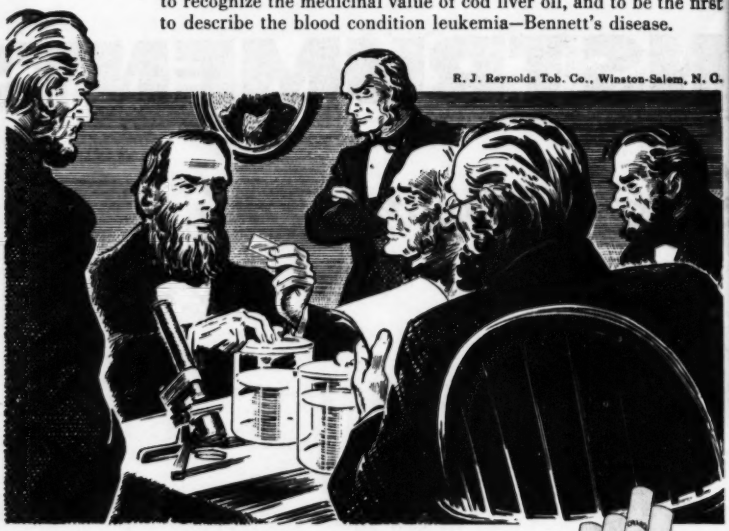

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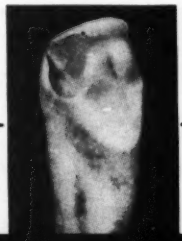

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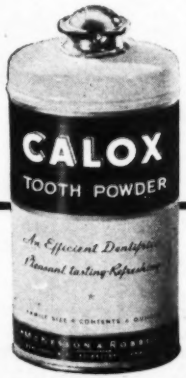

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Oral Hygiene

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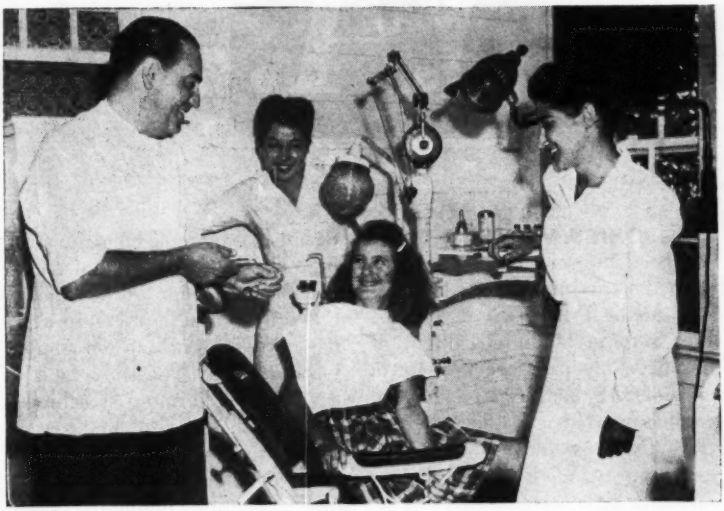
Forhan's *with massage*

FOR FIRMER GUMS—CLEANER TEETH

Picture of the Month



AT THE opening ceremonies of the dental clinic of the Wave Crest Convalescent Home, a home for indigent crippled children at Far Rockaway. New York, are (left to right): Doctor Lewis H. Spiegel, Director of Dental Service; Iris Seltzer, dental assistant; a patient from the home; and Mrs. Irene Annis, dental assistant. The clinic was a gift of the community to the crippled children. On its staff are a full-time dental intern and twenty-two attending dentists, all members of the Far Rockaway Dental Society. The services of the attending dentists and all supplies are donated.

Ten dollars will be paid for the picture used in this department each month. Send gloss prints with return postage to Oral Hygiene, 708 Church Street, Evanston, Illinois. The ten-dollar award for this picture will be used for the clinic.

The V.A. Review and Preview

By JOHN S. VOYLES, D.D.S.

As THE dental member of the Special Medical Advisory Group of the Veterans Administration, it has been my privilege to acquire considerable familiarity with the various activities of the Administration's Department of Medicine and Surgery. We have had the opportunity to inspect facilities of all kinds, and information concerning any department has been available at any time. As a private practitioner, but with access to this information, I have been in a position to form a few opinions. What I have to say is definitely not a statement of Veterans Administration policy, but purely that of a private practitioner with a knowledge of certain facts.

There is a crescendo of criticism of the participating dentist program. The growls at the modus operandi imply that the profession would like more efficient functioning. The Veterans Administration and the profession are engaged in this project as a partnership which has not been working too smoothly, and there is possibly fault on each side. If harmony is achieved, just what is this road we are to go down together?

The Veterans Administration has a definite obligation under public law. The profession has a certain obligation to society. It might be well to consider the obligations and limitations of each member of this partnership.

Veterans' Problems

As World War II was ending, the problem of the returning veteran was an absorbing political issue, aggravated by criticism of the old Veterans Bureau. It was obvious that the problems of the veterans from this long and largest of our wars would overwhelm any

existing facilities for their care. This applied not only to the health services, but to all the other benefits under veterans' laws.

The vast compilation of veterans' laws which started in the early 1800's is similar to other laws. Some may be wise, and some not so well planned. With some we may agree, and with some we may be at variance. Nevertheless, there they are, the will of the people, and the present Veterans Administration was set up to administer them.

In the health services, certain fundamentals were plain. The Administration was determined that the health service rendered by it was to be the best. This was only partly in recognition of the previous criticism, for it was a statement of a determined ideal and conviction. To administer such a program it was also clear that either a vast army of federal employees would be required or the enthusiastic cooperation of the professions involved must be obtained. The choice of the latter method was certainly the American way, and the American Dental Association may well feel proud that its own wholehearted and nationwide acceptance of the responsibilities made success of the dental problem seem assured.

Administration's Organization

To speed such a large program on its way, it was necessary to decentralize as much as possible, and

An adviser to the Veterans Administration gives his views of the Administration's dental program.

many woes arose from this need. The country was divided into districts; each almost autonomous in handling its medical and dental problems, with the choice of professional personnel left to the recommendations of the local dental and medical societies. Authority was not too clearly defined, and mistakes by one ineffectual person would often nullify the sincere efforts of a score of earnest people.

Just at a time when the organization began to need a check on its "growing pains," travel money was exhausted and it was impossible for responsible heads to visit the integral parts of the organization. A dawdling Congress further muddled matters. The deficiency appropriation languished, personnel ceilings were placed, and personnel was cut before a proper balance had been achieved. Zealous and unselfish experts who had forsaken more lucrative occupations for this program found their efforts about to be nullified. Even the current budget was delayed beyond the start of the fiscal year. Such things could disrupt even a smoothly functioning and efficient organization. In a sprawling newborn one, the effects were magnified many times. Gradually the program is being organized, the limitations resolving into major

and minor ones, and certain patterns are beginning to form.

The war pulled many of us from our "ivory towers" and, through close association, gave us a new view of our fellow practitioners. So, too, through the Veterans Administration's activities, it has been possible to get an appraisal of the private practitioners in the participating dentist program. The gripes of the practitioner were fairly and ably outlined in an article by George B. Fritz, in the October issue of ORAL HYGIENE.[1] To me, the complaints seem to center about slowness in receiving authorizations, and slowness in being paid. Let's ignore, for a moment, the causes for the delays, and the reforms that are now reducing them, and think of what might happen if, by some magic, the delays were all to vanish.

Dental Case Load

At the present time, with all the red tape and the aggravations, there are about 1,200,000 dental cases started, under way, or completed. As costs rise, it seems that these will cost between $86,000,000 and $100,000,000. These are taxpayers' dollars; dollars that shrink with each government bureau through which they pass. They are not the efficient dollars that pass directly from consumer to producer. If the unconscious barriers that red tape has raised were gone, how many more of the more than 18,000,000 other veterans would want dental treatment? What would that cost be?

Is this to be a program that is to go on year after year? Will it follow the pattern of other veteran benefits with continued expansion?

There are two clearly defined issues:

First, there is our responsibility to the veteran. Is the veteran of a foreign campaign to receive the same treatment as the inductee with six months' state-side duty? Does the amputee, the paraplegic, the blind veteran deserve the same benefit as the man who fought the war behind a desk? Educational benefits are based on months of service. The Canadian government provides a dental "overhaul" to all veterans with no further responsibility. Is there some just basis that we may find to render deserved dental service without being committed to a program that is becoming financially staggering, and which conceivably could become an impossible demand on dentists.

The profession has a moral responsibility. Do we wish to take the position that we must grab our share of public money? If we want to fight for a place at the public trough, then we sink to the level of the labor racketeer, the pressure groups, and we must enter into a competition to protect and enlarge our share of the "take" against other hungry aspirants. We will

[1]Fritz, G. B.: Veterans Administration Dentistry—Its Promise and Its Performance, ORAL HYGIENE 37:1722 (October) 1947.

have to stave off politicos and enter into a battle where fees and costs eventually will stifle professional ideals and progress.

Inpatient Program

There is one more serious danger. The participating dentist program is but half of a picture. The inpatient dental program of the Veterans Administration is concerned with those patients in hospitals and institutions. It is here that some of the finest service is being rendered, and it is here that the greatest gains are being made for the welfare of the patient, and the growth and progress of the profession. The residency program, the work done on plastic eyes, the restorations of facial damage, treatment of chipped bone grafts, postgraduate program for the Veterans Administration's dentists, research programs; these are the great opportunities for the veteran, and for the profession. If these programs are to suffer through difficulties in the outpatient program, the loss would be incalculable.

The Veterans Administration is supposed to *administer* such laws as the Congress enacts, with such funds as the Congress provides, with such personnel as the Congress allows, in the best manner it can. It cannot make or modify the laws. The profession has an obligation to society and to itself. It is here engaged in a partnership which may be leading us down a path it may not be wise to follow. It seems that it is time for courageous leadership to plan for a solution of the problem, rather than for criticism without foresight. We may commit ourselves to something we do not want.

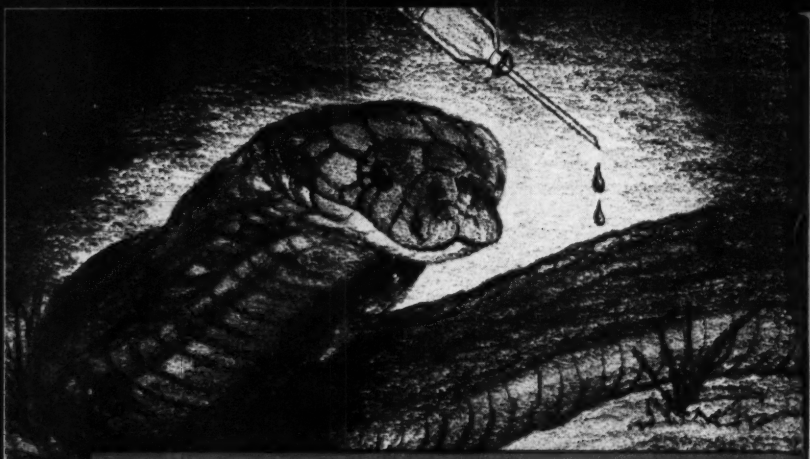
425 *de Baliviere*
St. Louis 12, *Missouri*

DISTRICT OF COLUMBIA MEETING IN MARCH

PLANS FOR a scientific meeting of high quality are being made by the Executive Committee of the Postgraduate Clinic of the District of Columbia Dental Society to be held March 14-18, 1948 in the Shoreham Hotel, Washington, D. C. under the general chairmanship of Doctor Marcus H. Burton. President of the Society is Doctor M. M. Alexander, and Doctor Francis J. Fabrizio is Chairman of Publicity for the meeting.

THE COVER

OUR COVER this month is dedicated to the Greater Philadelphia Dental Society whose annual meeting is to be held February 4-6 at the Bellevue-Stratford hotel in Philadelphia.



Snake Venom and Its Use in Dentistry

By CLAUDE W. CLIFFORD, D.M.D.

THE SECRETIONS of poisonous snakes have been known to the physician since the days of ancient Greece and Rome. A Hebrew physician, Maimonides, described their use eight hundred years ago in the treatment of cancer and leprosy. When the white man first crossed the great plains of the Middle West he found the Indians of the country using snake venom to cure what they called "fits." Again history is repeating itself but this time through medicine.

Recently a new interest has been exhibited in the empirical effect of venomous drugs, not only upon cancer, but other diseases as well. Rattlesnake venom is being used in the treatment of epilepsy, and moccasin venom in the control of hemorrhagic diseases. Cobra venom, however, is the most significant of these agents because of its greater field of usefulness.

Tic Douloureux

I became interested in cobra venom when I spent a few days with a practitioner who had used the venom successfully in the treatment of tic douloureux. I had a patient with this condition for whom I had expected to use the alcohol injection which is one of the usual ways of giving these patients relief from the excruciating

pain which they endure. The patient was an old man 80 years of age. The pain was in the upper jaw in the molar region on the right side. His teeth had been removed some time before, but the sharp, lancinating pains would occur, especially when he tried to eat or do much talking. I found his blood pressure to be 220 and his temperature one degree subnormal.

Use of Cobra Venom

I had him stay in a hotel near by where we could give him cobra venom injections as follows: The first three days we gave him 1 cc. of the venom each day. Then we skipped a day in between the next two injections. I then sent him home, telling him to come back in a week. At that time I gave 1 cc. and repeated this again in another week. At the end of the first three days of treatment his pain was gone and the blood pressure was reduced to 180. That was eleven months ago.

The other day an ambulance driver called me and said he was bringing me a patient who was in extreme pain. The patient proved to be the old man I had previously treated. I soon had him in a hospital and gave him immediate relief by the injection of 100 mg. of demoral followed by 1 cc. of cobra venom in an hour or so. This was repeated every day for three days. Then I stopped a day and gave another 1 cc. of cobra venom until the patient had received in all 6 cc. After he spent two extra days in the hospital I gave one more injection of the venom and sent him home. The demoral was given for immediate relief and the cobra venom for more permanent results. If the injections last eleven months again I will think the results excellent. This time the pain was in the lower jaw in the region of the mental foramen and not in the upper right region.

A physician whom I know has been treating a bedfast patient, a woman, for trifacial neuralgia. The pain, extremely severe, was along the right side of the face and head. After three injections of cobra venom the pain was gone and did not return for several months. Her blood pressure was reduced from 220 to 180.

Cobra venom is now used in cases of this kind to control intractable pain. Dentists and pysicians are using it in cancer-type diseases. It may be used with a greater margin of safety than the morphine drugs because it is not habit forming and the patient does not develop a tolerance; that is, the dosage does not have to be increased gradually as with morphine. "Side effects," produced when morphine is given, are absent; there is no eye change, the pupils remain constant, and men-

tal hallucinations are not present. It may be used alone or in conjunction with smaller dosages of narcotics. The effect is slower than morphine but usually of longer duration. This means the doses can be given further apart.

In this connection Doctor D. I. Macht, a physician, gives interesting findings from the results of his experiments with a group of twenty college students. These students were given mental mathematics problems to solve under normal conditions. Then he gave them problems under morphine and then again under cobra venom. The results showed that cobra venom quickened the mental responses with fewer errors while morphine, codeine, and other drugs lessened their mental efficiency.

Venom as a Hemostat

An eye, ear, nose, and throat specialist whom I know removed the tonsils from one of his patients in a hospital. The patient continued to bleed for three days although every known means was used to stop the hemorrhage. Finally in desperation he gave one intramuscular injection in the patient's arm of bothropic snake venom. The bleeding stopped in fifteen minutes.

Severe bleeding from the tooth socket has been controlled by packing the socket with this or other snake venom. However, in extreme cases it is sometimes necessary to inject as was done in the tonsil case. This little snake, about a foot long, is a native of Brazil. His bite is deadly to many who invade his habitat in the jungle. Your blood thickens like jelly within one minute if you are unfortunate enough to have his sharp fangs pierce your skin. Scientists have made him a benefactor to mankind by the proper and final reduction of his secretion to the proper consistency for medical use.

Snake venoms are protein animal poisons of a highly complex composition. They are generally colorless or slightly yellowish. In pure media (bacteria free) they may be preserved for years and still retain their original potency. In dried form they retain their death-dealing qualities. This dried venom is readily dissolved in water, alcohol, or glycerine.

Venoms are classified into two groups according to their respective actions. The first group is known as the neurotoxic because it affects the nerves. The other group attacks the blood and circulatory system and is therefore known as hemorrhagins. However, both classifications possess neurotoxic and hemostatic qualities to a certain degree. Cobra, coral, moccasin, and sea snakes are mostly neurotoxic.

Venom Compared with Morphine

Doctor Macht has done extensive research in the laboratory and clinically. His findings are enlightening as well as interesting.

Most of his research has been with cobra venom. His physiologic findings show that the venom is not a local anesthetic but rather affects the cerebrum and its higher nerve centers in about the same way that morphine does. The main difference is in the time element. Cobra is slow in acting while morphine and similar drugs produce analgesia quickly. The venom of the cobra lasts much longer as compared with morphine. This longer lasting analgesic effect of the cobra was explained by biochemical studies. He found that cobra venom and morphine acting on brain and muscle tissue give the following results: The oxidation of the morphine was rapid and chemically changed soon after coming in contact with the brain tissue. On the other hand, cobra venom remained unaltered for a long time. That then is the reason for the cobra venom action lasting for a longer period.

His studies of comparative effects of cobra venom and opiates on the sensations other than pain prove that cobra venom increases the acuteness of vision and hearing. The opiates, on the other hand, retard them. In tapping tests for muscular reaction cobra increased the rate while the opiates retarded the muscular performance.

To determine the effect of cobra venom on the liver and kidneys, rabbits were given heavy doses five or six days a week for twenty-two weeks. Functional tests made before and after the administrations showed that none of the animals had suffered an impaired function of the liver or kidneys.

Many laymen and not a few physicians have had a hesitancy about using snake venom. It has been considered a dreadful, death-dealing poison, and indeed it is when not used in suitable doses. On the other hand when a properly assayed solution is given, it may be a valuable therapeutic remedy for the relief of severe pain.

When using venom it is wise not to tell your patient what you are using. It is reported that patients knowing what is being used have developed psychic manifestations with faintness, nausea, and vomiting. These same patients, when told a different drug was being injected, have remained normal, although the same venom was administered.

1210 *Weatherly Building*
Portland 14, *Oregon*

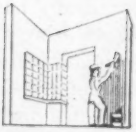
★ ★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by CLAUDE W. CLIFFORD, D.M.D., *has won the* $100 ORAL HYGIENE *award for the best feature published this month.*

★ ★ ★ ★ ★ ★ ★ ★

Office Modernization and Income Taxes



By HAROLD J. ASHE

THOUGH THEY admit the need for modernizing dental offices, replacing worn-out equipment, painting and repairing, many dentists postpone this step on the plea that exorbitant income taxes make new commitments inadvisable.

"How can I afford to have my office painted," a returned Service dentist complained, "when the government is taking almost one dollar out of every four of my net earnings?"

Like many Service dentists returned to civilian practice, he has been forced to lease an undesirable office on an "as is" basis. The walls and ceilings are thick with dirt, and the paint is peeling; plaster is ready to give way directly above his dental chair.

"My old patients seem to be loyal," he admitted, "but I'm afraid these surroundings aren't helping to add new ones."

An increasing number of dentists believe they have found an answer to this problem—at least as satisfactory a solution as is likely to be had until substantial tax relief is given.

In effect they say: Provided only that a paint job is needed, *the taxpayer cannot afford not to have such work done to keep his practice in a healthy condition and growing.* This conclusion has been reached only after careful consideration of income taxation.

While excessive income taxes

Are you practicing false economy by not modernizing your office during this period of high income taxes?

bear heavily upon dentists, and sharply decrease their take-home earnings, the situation is not quite as bad as some pessimists would have one believe.

The United States government, via income tax legislation, virtually has become a silent partner in every dental office in the country, sharing in net profits, if any.

With this fact in mind it should be emphasized that the government, as well as the dentist, shares in the additional net profits which accrue from economy measures of dentists.

While it is true that the economy-minded dentist can frequently increase his net profit by "cutting corners," by letting improvements go, getting along with antiquated dental equipment, neglecting the appearance of his offices—though in the long run such measures "boomerang"—it is equally true that the income tax collector extracts a greater "take" in income taxes as a result of such practices.

Long ago large taxpayers discovered that, income taxes considered, there is a point of diminishing return where economies are concerned. They have discovered that modernization of equipment, redecorating, replacing worn-out equipment, and other such expenditures not only are sound for the traditional reason of increasing profits, but they are doubly justified now *because they reduce income taxes by reducing taxable income through depreciation charges.*

Frequently professional profits are artificially increased beyond the norm because of shrinkage of depreciation costs caused by failure to make normal replacements and repairs as demanded by sound business practice. That is, a *real* additional income tax is assessed against a taxpayer because of an artificial profit which shows on the books even though, in fact, it merely represents postponing the day when replacements and repairs must be made.

Moreover, the taxpayer struggling along in an antiquated office with worn-out equipment is, in fact, often making lower profits than could be attained by modernizing and increasing the value of depreciable assets. Modernization may result in a sufficiently stepped-up net return over the years, so that even high taxes will not seem burdensome but will permit paying all income taxes and still leave take-home earnings greater than earnings previously were before income taxes.

Office Redecorating

Consider the case of the dentist mentioned. Completely redecorating his offices with a two-coat paint job might cost him $150. Because

TABLE I

Office Painting and Repairs (Maintenance Only)

(*Fully deductible in year incurred*)

Cost of Painting and Repairs	*Tax Rate (Less 5 per cent)*	*Year's Tax Saving*	*Net Cost of Painting and Repairs*
$100	20	$ 19.00	$ 81.00
150	22	31.35	118.65
200	26	49.40	150.60
250	30	71.25	178.75
500	34	161.50	338.50

Note: Tax rate is adjusted upward as the investment in painting and repairs increases. This sliding scale of tax rates for this and other tables has been selected arbitrarily for illustrative purposes only. The reader can figure out his own tax savings by determining the highest bracket any of his taxable income is in and using that rate to compute his savings and net cost.

this is a maintenance item, as distinguished from a depreciable asset, he may write it off as an expense incurred in that year.

If the taxpayer is in the $6,000 class and has $1,500 in personal exemptions and deductions, he has $4,500 subject to income tax, placing the top $500 in the 26 per cent (less 5 per cent) tax bracket. Even assuming that his net profit is not increased by such maintenance expense—though it should be, and that is his primary consideration in making the expenditure—this $150 paint job will reduce his $6,000 income to $5,850, and his taxable income to $4,350.

His yearly income tax (based on 1946 rates) will be reduced by

TABLE II

New Office Building (Exclusive of Land Value)

(*40-year useful life*)

Cost of Building	*Annual Depreciation*	*Tax Rate (Less 5 per cent)*	*Yearly Tax Saving*	*40-Year Tax Saving*	*Net Cost of Building After Tax Saving*
$ 5,000	$125.00	20	$ 23.75	$ 950.00	$4,050.00
7,500	187.50	22	39.19	1,567.60	5,932.40
10,000	250.00	26	61.75	2,470.00	7,530.00
12,500	312.50	30	89.07	3,562.80	8,937.20
15,000	375.00	34	127.50	5,100.00	9,900.00

TABLE III
New Fixtures and Equipment
(*15-year useful life*)

Cost of Equipment-Fixtures	*Annual Depreciation*	*Tax Rate (Less 5 per cent)*	*Yearly Tax Saving*	*15-Year Tax Saving*	*Net Cost of Equipment Fixtures After Tax Saving*
$ 250	$ 16.66	20	$ 3.17	$ 47.55	$ 202.45
500	33.33	22	6.94	104.10	395.90
750	50.00	26	12.35	185.25	564.75
1,000	66.67	30	19.00	285.00	715.00
1,500	100.00	34	32.30	484.50	1,015.50
2,000	133.33	38	48.13	721.95	1,278.05
3,000	200.00	43	81.70	1,225.50	1,774.50

$37.05. That is, the net cost of the paint job will be $112.95. In a left-handed manner the government, in effect, is paying $37.05 toward the paint job. Or, if the reader perfers, the dentist is paying the government an extra $37.05 in taxes for his failure to maintain his premises properly. Actually, during the life of the paint job, this dentist will probably make enough more to wipe out the net cost, and show a net profit on the transaction—even after taxes.

If this dentist were in the 30 per cent, 34 per cent, 38 per cent, or higher tax bracket, his tax saving would be even greater and the net cost of the paint job even less.

Or, a dentist may be considering the installation of new equipment and furnishings. The useful life varies as to items and, unlike painting or minor maintenance repairs, must be depreciated over a period of years. Taking a 15-year life as average, a $3,000 investment in such items may be depreciated at the rate of $200 a year. If the taxpayer is in the 30 per cent income tax bracket, the yearly tax saving will be $57. For the 15-year period, at present tax rates, this tax saving will total $855, making the net cost of this equipment, after taxes, amount to $2,145.

Again, a dentist may be debating the possibility of building his own dental office to escape high office rent and lease renewal uncertainties. Exclusive of land value, a modest individual office building might be constructed for $8,000. Setting up a depreciation table based on a 40-year life, this means $200 a year depreciation. In the 34 per cent tax bracket, such a dentist may reduce his income taxes by $64.60 a year. However, over the life of the building, at present tax rates, this would amount to

$2,584, a not inconsiderable sum of money in any dentist's statement of net worth.

Still another factor to be considered by dentists having growing practices is that tax savings will increase in subsequent years as net profits climb into higher and higher tax brackets.

Viewed in its true light, a maintenance outlay, or an improvement or replacement which originally looked too burdensome because of excessive income taxes, now comes into focus and may be practical precisely because of income tax laws.

Not only may modernization be financed by the taxpayer at considerably less than the cost price, he may benefit, profit-wise, at the same time.

However, in the final analysis, whether an individual dentist takes on such a program or not is strictly a personal problem, and one that he alone can decide. Certainly, however, he cannot make an intelligent decision without considering the income tax implications of such a step, and giving the tax aspect as much weight as, in other times, he would give to more commonly considered factors.

2002 *Knopf Street*
Compton, California

NEEDED INCOME TAX REFORM

THE INTERNAL Revenue Department has expressed concern over the income tax returns of physicians and farmers. The government considers that neither group is paying enough; that there are too many cash transactions that are not being reported; that books are not being kept accurately. The same suspicion is likely directed toward dentists.

If *all* expenditures for health service were tax deductible and if physicians, dentists, nurses, and hospitals were required to furnish each taxpayer with a receipt for money paid for services, the government would be assured of the exact amount of allowable deduction granted to taxpayers and the exact amount of income taxable to health workers. Under this system no one could cheat or be cheated.

If *all* health care were tax deductible, more people would spend their money for these needed services. The government can't lose. The deductible expenditures for health care would be chargeable against the earnings of health workers.

Whatever is spent on preventive and curative care will increase the life span of the taxpayer. Whatever increases his productive years will keep him paying taxes longer. It is good business for government to have the taxpayers earn long and live long.

Spotting the Neurotic Patient

This dentist discusses specific indications of neurotic personalities which you might like to avoid in your practice.

By JOSEPH MURRAY, D.D.S.

"CAN YOU put me to sleep, Doctor?" inquired the charming young patient of Doctor Roberts as she was ushered into his presence by the receptionist.

"Certainly," he answered. "Do you wish to have a tooth extracted?"

"No, my teeth do not hurt me now! Just fill my cavities while I'm asleep so I won't feel a thing."

"I suppose you want analgesia, or laughing gas," said the dentist.

"I just want to be fast asleep and awakened when all the work is finished."

Had Doctor Roberts paused to think, he would have proceeded with caution. Had he examined the patient's mouth, he would have been hesitant to treat her at all.

This pretty young girl of 18 had six badly decayed teeth—teeth beyond repair. Of utmost significance was the absence of a solitary

restoration in her entire mouth.

This patient was a neurotic. Her name might as well have been "Typhoid Mary." She was just as dangerous to Doctor Roberts' practice.

The number of such patients who present themselves for dental treatment is legion. Be on the alert! Never allow this type of person to become your patient! You will gladly pay her more than the contracted fee—to get rid of her, once you have begun treatment.

Patients who wish to be narcotized or placed in an unconscious state for operative treatment are mentally ill. Such persons cannot tolerate the hum of the engine motor. They cannot "stand" the grinding of the bur. They are even intolerant of light scaling. They are the type who refuse to look at the dental instruments.

Such patients usually are found to suffer from a fear complex or an anxiety neurosis. They should receive psychologic or psychiatric help.

Fault-Finding Patient

Another favorite neurotic is the patient who flits from dentist to dentist. His inner conflicts and emotional instability unconsciously drive him from office to office.

Beware when the patient says, "I can't find a good dentist." This type of person will usually find fault, always imaginary. "The other dentists never washed their hands or sterilized their instruments; they always left decay in the teeth; or they made cavities where none previously existed," is their lament.

If they were not guilty of the aforementioned failings, then these dentists were abrupt and businesslike. Besides, their fees were too high.

Never fail to ask a new patient, "Why did you leave your last dentist?" If you must accept a new patient who gives a history of transiency, you are at least forewarned—and can proceed cautiously.

"Efficiency Expert"

Another neurotic type is the patient who dashes into your office, glancing anxiously at his watch. "I can't wait, Doctor. Can you fit me in?"

Of course, it is difficult to recognize this "efficiency expert" in advance. It might be advisable to draw him out in conversation when taking his history. "Would you rather make an appointment in advance; or do you prefer to come in at your convenience?" This line of questioning can be followed even though you do conduct a strict appointment practice.

Should the patient show a preference for "barging" in at his own convenience, you can question him further: "Would you mind waiting if a patient with an emergency toothache requiring immediate attention presented?"

Even if the answer is in the affirmative, you could continue: "Does the nature of your business

cause you to break appointments frequently?"

If the answer is still in the affirmative, beware! This person will disrupt your practice. Finally, if you do accept such a patient for treatment, and you find that he upsets your routine, give him appointments a month or two in advance. If that does not discourage him from continuing his treatment, then you have effected a cure. He may even become an ideal patient.

Cancerphobia

A fourth type of patient to avoid is the cancerphobia patient. Women, especially those undergoing climacteric changes, are usually subject to such fears.

Quite frequently, they might have some hypertrophied gingival tissue. Often, the mouth will show signs of anemia or avitaminosis. Such patients often present certain forms of glossitis and fissured tongue. Many complain of burning sensation in the tongue and mucous membrane of the floor of the mouth. Some will display aphthous ulcers or cankers of the lips and mucous membrane of the cheek.

Nearly all such patients will show anxiety and frankly admit suspicion of malignancy. Of course, such complaints or evidence of lesions should not be ignored, but should be carefully investigated once treatment has been instituted.

Only when she presents herself as a new patient should you ascertain her fears and phobias. This type of person can make life unbearable for the dentist—especially if she is a denture patient.

The slightest irritation will cause her to return to your office, sometimes every day, including holidays, with the cry, "I'm getting cancer, Doctor. These dentures don't fit. Better make me new ones."

"Nervous" Patient

The fifth type is the "nervous" patient. This is a misnomer. She should be called the "nervy" patient. This type of person grabs your hand in the midst of a cavity preparation, or refuses to leave the operating room when her "nervous" child is being treated. This patient is mentally ill. She will show signs of emotional strain during the course of treatment.

Before accepting her into your practice, get a thorough case history—as you should with all new patients. Let the patient talk. Try to ascertain if there is a history of a nervous breakdown or any sign of mental illness in the immediate family.

Experience will be your best teacher. Remember that the elimination of all neurotics from your practice is an impossibility. Were you to limit your practice to normal persons only, you might as well close your office.

1358 *46th Street*
Brooklyn 19, *New York*

The Case of the Crying Child

By HARRY C. PEAKE, D.D.S.

THIS ARTICLE started out as THE CASE OF THE "HOWLING BRAT," but there is a difference—a vast difference—between a child and a "brat."

In fiction writing there is an important rule which must always be kept in mind by an author. It is simply: "Get into the minds of your characters." And that is the secret of handling the crying child—or any child, for that matter. Get into his mind; find out what he is thinking; *why* he is crying.

Psychologists tell us a child is born with only two fears—the first is the fear of falling; and the second is the fear of a loud noise.

There is little possibility of a child falling in a dental office, and any dentist is well advised not to attempt to be a "big noise" in front of his juvenile patients.

Children's Fears

However, as a child grows older, other fears are added to the basic two. Sometimes this is the result of fond parents threatening to take their recalcitrant offspring to the dentist if he does not behave as they think he should. Others, by the time they reach the advanced age at which their teeth become carious, are so filled with fairy tales by the other children that a

This dentist's suggestions for handling a frightened child in the dental office may prove helpful to you.

dental office appears as the den of an ogre, and the dentist as the heir apparent of Satan himself.

One good way to start getting into the minds of young patients is to get down on the floor of the operating room when there is nobody around to take advantage of your position. Place your head at the height of a 5-year-old, and take a good look at the equipment. See what I mean? It is awe inspiring, is it not?

Winning Confidence

In our office we have nothing but sympathy for the child who is genuinely frightened. However, unless you have the whole day to spend on the case, it is much better to show that sympathy *after* the operation is completed. We are busy enough at the start winning the confidence of the patient.

Children are like adults in many ways. The adult does not take his car to a garage where he has no confidence in the mechanics. The child has no choice about the dentist to whom he is taken, but he can express his pleasure or displeasure at the selection his parents make.

Here is where getting into the mind of a young patient is necessary. What does the child expect? Unless the parents have deliberately frightened him, they will have told him he is going to the dentist to have his teeth "fixed." That means he does not enter the office with the idea that he is coming to some sort of playground. He associates the professional man with dignity—not the "stuffed-shirt" variety of behavior some men adopt—and he expects the dentist to be dignified. Not pompous, but dignified, in a kindly way.

Child's Individuality

The greatest mistake a dentist can make with his young patients is to "talk down" to them. The child is an individual, and he is proud of his individuality. To talk down to him is insulting this individuality, and he does not take kindly to it. We always try to meet the child on a plane which he can understand, but which is above rather than below him.

We do not try to amuse our young patients, but we *do* explain every move we make. We never make a quick move which the child is not expecting, and we never use an instrument without explaining its purpose as we go along. Even a blast of air will frighten a child if used quickly without any explanation. However, if the child knows it is air—and not some kind of lethal gas which his imagination may have conjured up—and knows that its only purpose is to dry the cavity, he will not care how much it is used.

If the average dentist were to be

taken into the engine room of a large ocean liner, he might be curious, but he would be suspicious of everything he saw. The Chief would take him around and explain the functions of the various parts of the machinery, and as this went on, the dentist's suspicions would gradually disappear. But the Chief would not talk in the language he would use with another engineer. Neither would he use baby talk.

That is the way it must be in a dental office. Explain everything to the young patient, but do it in a language he will understand—as man to man, and not like some dowager cooing over a baby carriage.

Undisciplined Child

We find this form of treatment usually takes care of the case of the crying child. But then there is the "howling brat." When this type of child is dragged into our office, my assistant goes into action. The doting parent is informed that his offspring is a high-strung child. She explains the danger of giving him a fright which might stay with him for years, and suggests the parent spend a little time on an educational program before bringing him in for an appointment. She also suggests that such a nervous patient should be taken to a pedodontist. In other words, she tells the parent to either teach the "brat" some manners and control, or go somewhere else. But she does it in such a way that the parent leaves our office with the idea we are genuinely interested in the welfare of the child.

To handle a nervous child requires patience, understanding, and kindness. To handle some of the little "demons" which are brought to dental offices requires the "laying on of hands." However, it is not the place of the dentist to administer discipline. It takes far too much out of a man who is practicing under a high tension to have to *force* his services on a patient. So, in our office, the crying child receives understanding and treatment, but the "howling brat" is politely but firmly ushered out.

Timberlea
Parkhill, Ontario
Canada

AKRON TO OBSERVE CHILDREN'S DENTAL HEALTH WEEK

THE AKRON, Ohio, Dental Society will present its eighth Children's Dental Health Week February 1 through 7. An extensive program to stimulate both lay and professional interest in dental care for children has been planned. Doctor Ralph L. Ireland, pedodontist and professor of children's dentistry at the University of Nebraska College of Dentistry, will be the main speaker.

So You Know Something About Dentistry!

QUIZ XL

1. Hypocalcification is (a) seldom, (b) frequently, (c) almost always, distributed bilaterally. .....

2. Irregular dentine formation or a wide layer of primary dentine tends to (a) minimize, (b) aggravate, (c) have no effect upon, the irritation of silicate cements to the pulp. .....

3. Which is the most active muscle of the cheek? .....

4. The dentition in normal occlusion is completed (a) earlier than, (b) later than, (c) the same as, the dentition in malocclusion. .....

5. Nitrous oxide used as an anesthetic for short operations is (a) mixed with 10 per cent of oxygen, (b) used alone, (c) mixed with 20 per cent of oxygen. .....

6. If mucin in the saliva is deficient, will the wear of the teeth be (a) retarded, (b) normal, (c) abnormally rapid? .....

7. The percentage of patients 50 years of age or over with bridge requirements is (a) 30 per cent, (b) 17 per cent, (c) 5 per cent. .....

8. What is a unit of penicillin? .....

9. The cystic margin of a radicular cyst is (a) radiopaque, (b) radiolucent. .....

10. To all intents and purposes can the maxillary sinuses of both sides be considered symmetrical? .....

FOR CORRECT ANSWERS SEE PAGE 60

Dean Timmons, of Temple University School of Dentistry, addressing members of the Hudson County Dental Society.

New Veterans' Postgraduate Center Opened

In the laboratory of the Hudson County Dental Society's Veterans' Postgraduate Center during the dedication program are (left to right): George O'Hanlon, M.D., Medical Director of the Jersey City Medical Center; Honorable Frank Eggers, Mayor of Jersey City; Arthur H. Lipman, D.D.S., President of the Hudson County Dental Society; and Frank J. Houghton, D.D.S., Dental Director of the Jersey City Medical Center.

Hudson County Dental Society dedicates modern postgraduate center for the use of Society members.

AT THE formal dedication of the Hudson County (New Jersey) Dental Society's Veterans' Postgraduate Center, Doctor Gerald D. Timmons, Dean of Temple University School of Dentistry, declared that the Society had provided the greatest physical setup for dental training that he had ever seen. The Center, located in the surgical building of the Jersey City Medical Center, is equipped with modern facilities for postgraduate courses and training in dentistry. Established to honor the Society's veterans of World War II, its facilities are open to the entire membership of the Dental Society.

The Center's main room is a modern laboratory equipped with four stainless steel-topped tables which have two operative engines and handpieces on each, and air, gas, and electric outlets for eight students working at each table simultaneously. A table equipped with all laboratory facilities is built upon a podium for the use of the instructor. The room is also quipped with a stainless steel-topped plaster table with a plaster sink at one end, and a stainless steel casting table 15 feet long with a large casting machine sunk in a well.

Eleven fluorescent lighting fixtures provide a maximum of light throughout the entire room.

A dental library with modern bookcases, large tables, and sufficient chairs to serve the membership is located adjacent to the laboratory. The funds for furnishing

Hudson County dentist-veterans in the laboratory of the Postgraduate Center. In the background are Gerald D. Timmons (left), Dean of Temple University School of Dentistry; and Walter Wright, Dean of New York University College of Dentistry.

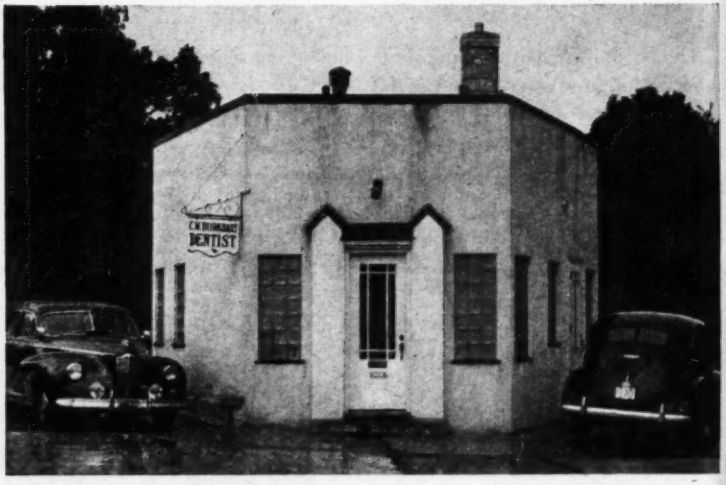
the library were donated by the Alpha Omega Club of Hudson County.

A fully equipped operative room, complete with unit, chair, and an amphitheater for practical demonstrations and lectures, is to be added to the Center. The furnishings and equipment will be donated by the dental veterans of Hudson County as a memorial to the late Doctor Maurice Appel, of Jersey City, who died in action in the South Pacific.

Doctor Frank J. Houghton, Dental Director at the Medical Center, headed the committee appointed to establish the Postgraduate Center. During the dedication ceremonies, Doctor Salvatore T. Rifici, Chairman of the Society's study club, announced that postgraduate study in the Center would begin within two weeks of its opening.

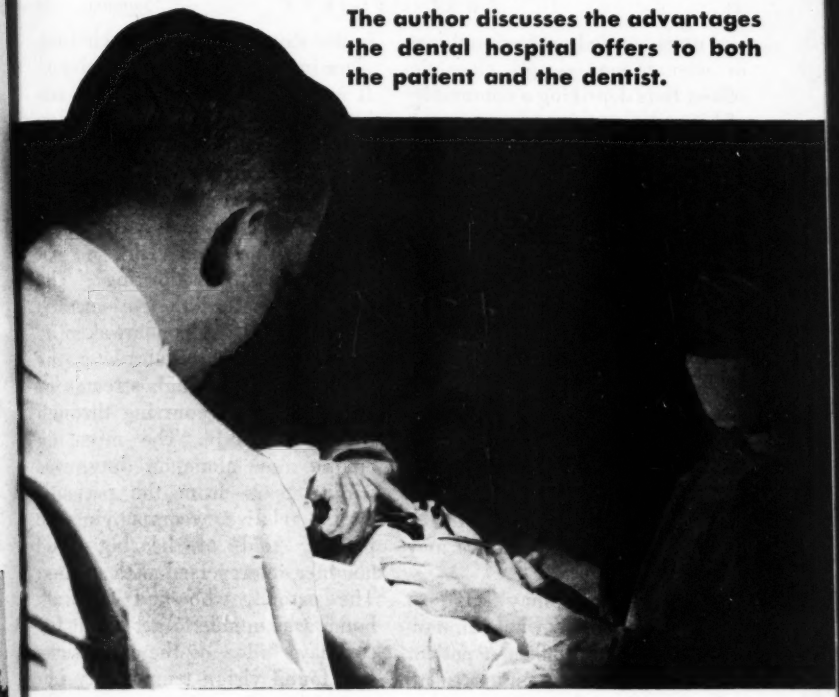
Following the formal opening and inspection of the Center, a clinical program was held, conducted by leaders in various phases of dentistry.

AN UNUSUAL DENTAL OFFICE



THIS FORMER filling station at 2500 West Broadway, Minneapolis, Minnesota, solved Doctor C. W. Burkhart's problem of no dental office space. When the dentist found the building standing vacant, he took it over; installing air conditioning, a modern interior with indirect lighting, and full dental equipment. It now contains nine small rooms.—*Photograph courtesy of Milton B. Kihlstrum.*

The author discusses the advantages the dental hospital offers to both the patient and the dentist.



A Patient Considers the Value of the Dental Hospital

By EVELYNNE SIEBERT

THIS PATIENT, looking at the dentist, first considers the high cost in time, money, effort, and sacrifice required to gain the degree of D.D.S. Then comes the equipping of an office with expensive operational machines and instruments; high office rents as well as the dental assistant's salary. Thereupon the young dentist begins to build a practice. Patients may be slow in coming, and soon a promising

and much needed professional man or woman may simply close the office; thus depriving a community of his or her services.

Recent Dental Graduates

Frequently a new dentist starts out with an older, more experienced, and financially secure man. This often leads to unpleasant relations and soon results in a breaking away with some memories, bitter and resentful.

The dentist, starting practice alone, is often at great disadvantage because, being intent on making his chosen profession repay him, he spends longer hours at his dental chair than could be called healthful. His practice may then suffer.

A case history may serve to show young dentists what can happen in a one-man office. A patient made an evening appointment with a dentist; the assistant not being on duty. The patient's mouth had not been roentgenographed and the dentist was not aware, until difficulty developed, that the second molar he was to extract had curved its roots around those of an impacted third molar. Then followed a bad hour; the patient finally emerged with a serious hematoma in the cheek, a discolored, swollen face. Three weeks of misery followed, and at least a year during which the jaw muscles did not function properly.

Another case concerning a patient who had been ill, and who developed an acute abscessed tooth, is the story of events which took place in a university dental school! It was determined that nitrous oxide gas be used; the extraction cleared quickly and caused no further difficulty. But, in the memory of that patient, there remains the fact that the anesthetist asked only one question: "Did you eat any breakfast this morning?" The reply being "No," the patient took the anesthetic. Upon awakening fifteen or twenty minutes later, the patient felt as though streams of hot steam were coursing through the entire body. The nurse in charge, now alone on duty, was wiping tears from the patient's eyes. A relative, accompanying the patient, told of hearing loud laughter interspersed with crying. The patient, who had to walk home, was unable to get about for two days following the extractions and found vision temporarily impaired.

Teaching of "patient psychology" was evidently at a low ebb in this dental school.

Internships for Dentists

If there were, within a few hundred miles, a dental hospital, the young dentist might serve an internship there, becoming familiar with people, their problems, both personal and financial, and thus be prepared to carry on his own practice more successfully. He would keep his patients, and learn by doing under the guidance of specialists.

There are in the United States

millions of potential dental casualties resulting from the tragic underfeeding which most of us experienced in the 1930's. Children born during those years are in danger of becoming denture patients in their twenties. They are going to require dental services far beyond those now available to the moderately salaried person. Dental hospitals might meet this coming need.

The dental hospital, entirely separated from medical institutions and away from the life-and-death atmosphere surrounding them, might be considered. Perhaps a physician might be the admitting officer, permanently charting the necessary medical history of each patient. This, if followed by the setting up of a dental chart by an examining staff dentist, would allow any qualified man to be assigned to any patient.

Dentists, as a whole, are proud of the good service they render, and, thus, specialists could practice unhampered. Patients would benefit greatly, both through conferences on procedures and from research data, along with knowledge of diets necessary to dental health.

It would seem highly important that a patient having multiple or severe dental extractions be treated as a hospital patient, spending a few days in bed under properly prescribed postoperative administrations. In order to keep costs within paying ability, practical nurses, trained in the dental field, might be used. The professional staff might be augmented by volunteers who are generous in giving time to worthy, charitable organizations.

In considering the costs of maintaining the dental hospital, let us examine actual figures applying to a family's present dental needs. For example, a family's income is $35.00 per week, paid semi-monthly. There are three members of the family needing dental care, two children, one adult. Because of past conditions, such as lack of money, and shortage of dentists in the area in which this family lived, present dental services required for two members of the family are: five extractions, $15.00; two prophylaxis and examinations, $8.00; two restorations at $8.00. This totals $31.00. The other child requires about $40.00 worth of treatment. The entire amount needed will be about $75.00. The adult will remain "stranded" because a glance will show the length of time this treatment must continue.

Dental Insurance

However, this same family carries hospitalization. They pay, to cover three people for one year, the sum of $76.26. No services having been needed during that period, this family has, in a sense, been paying the hospital bills of patients who did need care. In view of the fact that these payments must have been duplicated many times by other insured persons,

would it not be safe to believe that dental coverage could be extended to patients for all needed operations? Schools, as a whole, might be covered; the Parent-Teacher Associations being sponsors.

A letter regarding dental coverage recently was addressed to an insurance company which advertised its hospitalization plan. This brought a letter from its president who stated that the company's actuaries could not learn just what rates they might use in setting up premium rates because of a wide divergence in dental fees.

Dentistry, so important to human needs, must be presented prominently and forcefully to the people. It must advertise its use of the most modern and finest equipment, eliminate the long waits in the reception room, and by taking "fear" from the minds of patients, go forward, with the medical profession, to a brighter, happier future.

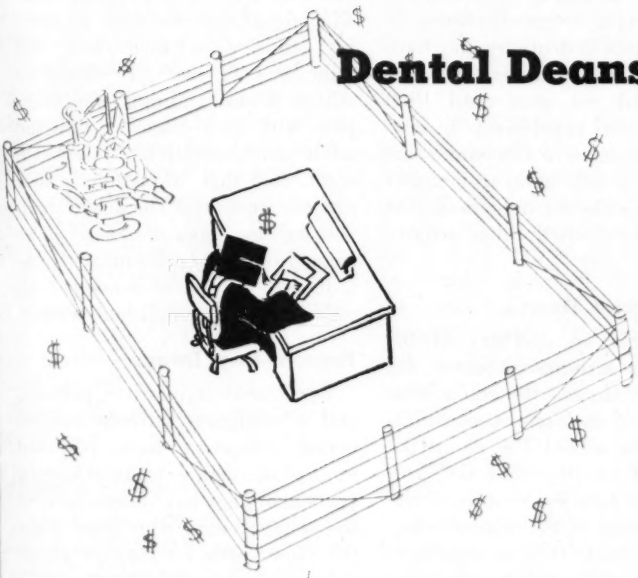
Sulphur Springs Hotel
Tampa 4, Florida

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

Answers to Quiz XL (*See page 53 for questions*)

1. (c) almost always. (Robinson, H. B. G.: A Clinic on the Differential Diagnosis of Oral Lesions, Am. J. of Orth. & Oral Surg., 32:733 [December] 1946)
2. (a) minimize. (Zander, H. A.: The Relation of the Dental Pulp to Silicate Cements, J.A.D.A. 33:1243 [October] 1946)
3. Buccinator. (Anthony, L. P.: The American Textbook of Prosthetic Dentistry, 7th Edition, Lea & Febiger, 1942, page 115)
4. (a) earlier than. (Tarasido, Rodolfo: The Face and Its Development, Am. J. of Orth. & Oral Surg. 32:631 [November] 1946)
5. (b) used alone. (Accepted Dental Remedies, 12th Edition, American Dental Association, 1946, page 46)
6. (c) abnormally rapid. (Stillman, P. R., and McCall, J. O.: A Textbook of Clinical Periodontia, 2nd Edition, MacMillan, 1937, page 68)
7. (c) 5 per cent. (Tylman, S. D.: Crown and Bridge Prosthesis, Mosby, 1940, page 19)
8. The amount which when dissolved in 1 cc. of liquid will prevent the growth of a standard strain of S. aureus H in a zone about 22 mm. in diameter on an agar plate. (Hoffman, W. S.: Penicillin: Its Uses and Possible Abuse, J.A.D.A. 34:91 [January] 1947)
9. (a) radiopaque. (Thoma, K. H.: Oral Pathology, Mosby, 1941, page 657)
10. Yes. (Mustermann, H. W.: Principles and Practice of X-Ray Technic and Interpretation, Dental Items of Interest, 1945, page 145)

What Price Dental Deans?



A colleague discusses the position of the dental dean in present-day schools of dentistry.

By ***JOHN W. COOKE, D.M.D.***

WITHIN twenty years, considerable black ink has been used to show what was wrong with education in dentistry. Much of this was inspired by the Carnegie-Gies report in 1926. Since 1940, certain changes have taken place designed to improve the education of a dentist. Some of these changes have been good. Whether the long-time trend is to be good is not for me to say.

In attempting to integrate dentistry with medicine, there has come a startling change in the quality of *deans* of dental schools. A portion of this change is worthy of some scrutiny.

World War I brought some prominence to dentists and to dentistry. This was achieved by individual practitioners and accepted by the group, which was pleased by new rank and privileges for commissioned personnel in the armed forces. Following the war,

teachers in dentistry returned wearily with their deans to take up the four-year course, and the later increased so-called predental requirements in accepted colleges.

Educators in dentistry may have hoped for a new student demand, but it did not start until 1940 when various experiments in dental education were receiving some attention, mostly unfavorable; giving credence to the hypothesis that any publicity is better than no publicity.

Commercial Deans

The dean in dentistry of the 1920's was an unusual person. He had to be. He was the administrative head of an *insolvent* organization, if the school was connected with a university, and the promoter of a *business* venture, if the head of one of the several commercial schools then in existence. If the former, his title as dean gave him rarely more than a year's security. Consequently, he built his fences around some clinical appointment and not infrequently employed his prestige to maintain a profitable private practice. The so-called commercial dean kept his fences mended with dollars, when he could get them, and usually paid himself well and his teachers poorly, a well-known practice still extant at the present time.

To my knowledge, there were no deans of independent wealth. A few of the more astute earned large incomes as dentistry goes, and were revered, hated, or feared; depending on which faction one asked for information. They were, almost without exception, tyrants, often benevolent, and divided their educational time between promoting dentistry and themselves, and fighting with medical educators whose dental training was complete with their discovery that the adult human mouth had thirty-two teeth. Not that it mattered: any number would do. The dental dean was fighting against himself if he begged or stole endowments. Consequently he recommended both mildly—but accomplished neither.

Present-Day Deans

Age, new university policies, and a changing attitude toward dental education have removed most of the dental deans of twenty years ago. They have been replaced by younger men who must fight the same battle over again under different and more difficult conditions.

This comment should be enlarged upon.

A dental dean encounters students, dentists, clinicians, and investigators. He is expected to have some administrative ability. If he happens to combine an effectual promotional sense with a circle of suitable acquaintances, he may be welcome for money raising. In this capacity, however, he becomes a competitor of his medical school dean and of his university president, each or both of whom may have abandoned reluctantly careers in teaching or research for the ex-

tremely precarious task of seeing black ink on as many departmental budgets as possible.

The dental dean is the head of a *red ink* department. There have been *no profitable* dental schools since the days of the commercial dental college. Consequently, to keep his position, he must offend as few people as possible and attempt to convince his governing authorities that the deficit would be twice as big without him. This is a balancing act worthy of a "big-time" circus; a consistent phenomenon, since dental education, courting government and foundations at the same time, is well on the way to becoming a "big-time" if still unprofitable business.

Financial Security

The former dental dean built his personal fences and kept them mended. He clung to everything, including his private practice. The present incumbent has nothing to fence except his reputation as an educator and scientist, and may seek public notice with a view to stepping up in the dental educational circle. There are a few administrative jobs in dentistry paying fairly good salaries. One can be sure that these positions are eyed carefully by today's dental deans. For even their modest bills must be paid and their families fed.

In the meantime, capable men enter the practice of dentistry and discover in it an adequate road to security for themselves and their families. They cannot make the sacrifice of swapping an assured position for an uncertain one. And they are ceasing to live in awe of deans of dentistry. They neither love nor hate these men. They are sorry for them. And that is a pity.

Ask any dental dean how secure he feels. If you know him well enough, ask him if he can live on what he is paid. Ask him if the uncertainty is worth the title.

Dentistry will get and *keep* good deans and teachers when they are paid adequately—and when the positions offer more than a semblance of protection and security.

60 *Charlesgate West*
Boston 15, *Massachusetts*

DENTAL EQUIPMENT STOLEN

Doctor M. M. Bergholz, 69-81 108th Street, Forest Hills, New York, reports that the following equipment was stolen from his dental office: a new Ritter lathe, serial number 5 C 37509; Bausch & Lomb microscope, model HA-8, serial number 258339, objectives: 16 mm. 14805, 4 mm. 26971, and 1.8 mm. 23866; a Garhart amalgam dispenser; and 1000 ¼-grain codeine sulphate tablets.

According to the police report the burglar entered Doctor Bergholz' office on a Sunday, using either a pass key or a skeleton key, as there was no forcing of the window or the door and no fingerprints.

Portraits and Profiles

OF AMERICAN DENTISTS

By HOWARD A. HARTMAN, D.D.S.

Officers of the National Physicians Committee and the National Committee of Dentists meet in Chicago.

Left to right: William F. Braasch, M.D., of Minnesota, Secretary of the N.P.C. Board of Trustees; A. P. Williams, D.D.S., of Kentucky, Chairman of the N.C.D. Executive Committee; William Bates, M.D., Secretary-Treasurer of the Pennsylvania Physicians Committee; Edward H. Carey, M.D., of Texas, Chairman of the N.P.C. Board of Trustees; Joseph B. Zielinski, D.D.S., of Illinois, Secretary-Treasurer of the N.C.D. Executive Committee.

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Standing (left to right): Edwin C. Ernst, M.D., of Missouri, N.P.C. Board of Trustees and Chairman of the Greater St. Louis Physicians Committee; Harry B. McCarthy, D.D.S., Chairman of the Maryland Dentists Committee; Arthur J. Buff, D.D.S., Chairman of the Kansas Dentists Committee. Seated (left to right): Wilbur McL. Davis, D.D.S., Chairman of the Florida Dentists Committee; Arthur L. Conrad, Associate Executive Director of Medical Services Foundation.

Left to right: E. R. Brownson, D.D.S., of California, N.C.D. Executive Committee; C. E. Umphrey, M.D., Chairman of the Michigan Physicians Committee; Ralph B. Rode, D.D.S., of Missouri, N.C.D. Executive Committee; M. H. Petersen, Associate Administrator of N.P.C. and N.C.D.; Olin Kirkland, D.D.S., of Alabama, N.C.D. Executive Committee; John S. Bouslog, M.D., President of the Colorado Medical Society; Carl H. Gellenthien, M.D., Chairman of the New Mexico Physicians Committee.

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Left to right: George C. Brown, D.D.S., Chairman of the Massachusetts Dentists Committee; D. B. Reardon, M. D., of Massachusetts; J. P. Burke, D.D.S., of Washington, D.C., N.C.D. Executive Committee; W. C. Thomas, M.D., Chairman of the Arizona Physicians Committee; A. A. Brindley, M.D., President of the Ohio Medical Society; Elmer Hess, M.D., of Pennsylvania, Medical Services Foundation Board of Trustees; Frank W. Rounds, D.D.S., of Massachusetts, N.C.D. Executive Committee.

Left to right: James J. Vaughn, D.D.S., Chairman of the Tennessee Dentists Committee; R. W. Fouts, M.D., of Nebraska, Speaker of the A.M.A. House of Delegates; Edward L. Thompson, D.D.S., of Florida, N.C.D. Executive Committee; Joseph B. Zielinski, D.D.S., of Illinois, N.C.D. Secretary-Treasurer; A. P. Williams, D.D.S., Chairman of the N.C.D. Executive Committee; M. A. Shillington, M.D., President of the Montana Medical Society.

★

Left to right: C E. Peterson, D.D.S., Chairman of the Connecticut Dentists Committee; Oren Oliver, D.D.S., of Tennessee, N. C. D. Executive Committee; Edward H. Carey, M.D., of Texas, Chairman of the N.P.C. Board of Trustees; William F. Braasch, M.D., of Minnesota, Secretary of the N.P.C. Board of Trustees; J. C. Shields, M.D., Chairman of the Montana Physicians Committee; Fred A. Richmond, of Kansas, N.C.D. Executive Committee.

Dentists in the News

Cleveland (Ohio) News: Doctor Walter Brehm, of Logan, Ohio, who besides being a dentist is a United States Congressman, told dentists attending the annual convention of the Ohio State Dental Association that the government has neglected its duty in not setting aside research grants for the dental profession. "All research in dentistry to date has been financed by dentists or those interested in the profession," he stated.

At the next session of the Congress, Doctor Brehm will introduce a dental research bill asking for a government grant to set up a research center at the Naval Hospital in Bethesda, Maryland. He believes a dental health program should be established there in conjunction with the medical health program.

Doctor Brehm also expressed the belief that dental care for the indigent is a social obligation for the government and not for the profession.

Pittsburgh (Pennsylvania) Sun-Telegraph: The "North Pole Dentist," Doctor Bert LaRue, has flown north in his ninth new airplane. In fifteen years of practicing dentistry in Alaska, he has worn out the other eight. He is under contract with the territorial government to provide dental care for the native Alaskans along a 1,700-mile route. It takes him eighteen months to make his rounds.

This dentist reports that most Alaskans have healthy teeth from chewing and softening hard sealskin, but he is often asked to restore teeth with bright stones.

When Doctor LaRue first went to Alaska, he travelled with a dog team. Since learning to fly, he has accumulated more than 10,000 hours in the air. The Alaskan summers and winters, from the Bering Sea to the Canadian border, require seasonal changes on his airplane.

St. Louis (Missouri) Post-Dispatch: In an address before the St. Louis Dental Society, Doctor Herbert K. Cooper, a dentist and Director of the Lancaster (Pennsylvania) Cleft Palate Speech Clinic, stated that institutions devoted to the rehabilitation of persons suffering from defects of the oral cavity are needed urgently in this country.

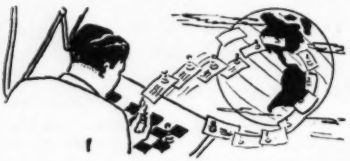
"Institutions for cripples suffering from other physical deformities, which occur less frequently at birth, have been established, but no real effort by the public health institutions has been made to correct palate defects," Doctor Cooper stated. He pointed out that palate abnormalities occur in one out of 800 live births.

Doctor Cooper reported that persons suffering from defects of the oral cavity need not only the prosthetic devices designed for them, but personality rehabilitation also. "In too many cases," he said, "young people with such a defect become introverts and shy away from healthy relationship with society."

Bedford (Indiana) Daily Times-Mail: For sixty-one years, 83-year-old Doctor J. G. Hogan, a Bedford dentist, has

been playing chess with top players of most of the forty-eight states and many foreign countries. He has been practicing dentistry for the same length of time.

In following this hobby, this dentist has played thousands of games of chess both by correspondence and in person-to-person matches. He finds correspondence chess fascinating. Through the



Correspondence Chess League of America, he has played matches with soldiers scattered over the world. A special written code, which Doctor Hogan said the U. S. Army frowned upon, enables the players to signal their moves to the opponents. The Correspondence Chess League of America keeps records on the participants and periodically publishes their standings.

Doctor Hogan learned to play chess when he opened his first dental office in Norfolk, Nebraska, in 1886. "A lawyer taught me the game," he reports. "Winters were long and cold in that small Nebraska town, and the lawyer whose office was near mine taught me the rules and some of the strategy to help kill some of the lonely hours."

Chicago (Illinois) Sun: Doctor Frank G. Kuchler, a Chicago dentist, is wondering how many people there are throughout the world to whom he will have to pay $5. He is expecting letters from almost anyone who lives on a seacoast.

The reason for this is that a friend of his placed his name in a number of bottles which he dropped overboard into the Pacific Ocean while on a trip to Australia in 1941. Each bottle held a note reading: "Finder please report to Doctor F. G. Kuchler, 7858 South Ashland Avenue, Chicago, U.S.A., and receive $5 reward."

Doctor Kuchler paid $5 to a man in Sydney, Australia, who recently found one of the bottles.

Des Moines (Iowa) Tribune: When Doctor Raymond F. Langland, a Madrid, Iowa, dentist, wanted an "outdoors" place to camp and fish which would be accessible to his home and office, he bought a seven-acre tract for $30 in Elk Rapids, a community which was originally settled in 1840 but had been deserted since 1870. Located on the bank of the Des Moines River two miles from Madrid, this attractive spot is an ideal place to relax and enjoy the life of a sportsman. Here he built a modern cabin on the river front, planted hedges where horse weeds once grew, and put in a lawn where rubbish once stood.

During the summer Doctor Langland can spend a couple of hours fishing before going to his dental office, and at noon he can drive out to his cabin for lunch.

Eight cabins and cottages have now been built along the river, and from early spring until late fall Elk Rapids provides an ideal location for picnics and outdoor sports.

Philadelphia (Pennsylvania) Evening Bulletin: While Doctor Peter Caprow, a Chicago dentist, stood waiting for a streetcar, one coming from the opposite direction shot him. The streetcar touched off a bullet which police believe was placed on the tracks by pranksters. Doctor Caprow was wounded in the leg and needed hospital treatment.

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

PHILIP S. FREEMAN, D.D.S., 6645 Castor Avenue, Philadelphia 24.
R. B. MOORE, D.D.S., P. O. Box 162, Columbus Junction, Iowa.
WALTER J. BOCZEK, D.D.S., 5458-A Lillian Avenue, St. Louis 20.
JOHN T. KENNEY, 1305 West 108th Street, Cleveland 2.

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

DENTISTS ADVISED TO STUDY PATIENTS' PERSONALITIES

INDICATIONS OF dental conditions or facial pains frequently can be traced to emotional origins, according to Doctor Edward Weiss, Director of Research in Psychosomatic Medicine for the National Committee of Mental Hygiene, who spoke before the First District Dental Society of New York.

"The work of the dentist may have significance far beyond the superficial, purely mechanical ideas that are usually associated with dental extractions," Doctor Weiss, who also is Professor of Clinical Medicine at Temple University, stated. "If he becomes a little more aware of the structure of the personality, in the same way that he is now aware of the structure of the mouth, he may avoid many unfortunate occurrences. The teeth can be no more divorced from the personality of the patient. so far as psychosomatic medicine is concerned, than any part of the body.

"Many pains about the head, face, and neck are wrongly assumed to be caused by dental pathosis," Doctor Weiss said. "Teeth are extracted, or sinuses operated upon, when a careful analysis of the pain would show that a typical neuralgia caused by focal conflict rather than focal infection is present. A study of the life situation rather than a search for foci of infection is the proper approach."—*New York* (*New York*) *Times.*

Editorial Comment

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

THE VETERANS ADMINISTRATION NEEDS OVERHAULING

THE VETERANS Administration dental program is not what it should be. Neither the veterans nor the dentists are happy, and the taxpayers are liable for a stupendous bill payable over the years.

The Veterans Administration promised too much and delivered too little. The program expanded too fast without careful planning and the money ran out too soon. Any business that goes in over its head, has too many employees, and runs out of money goes into bankruptcy. A private business cannot go with hand extended to the federal treasury and ask for additional funds. The Veterans Administration is guilty of these errors of bad management: poor long-term planning, rapid and ill-conceived expansion, needless red tape, slowness in paying bills, abominable professional relations.

When the dental program began veterans were encouraged to apply for treatment if there was the slightest evidence of service-connected disability. By thousands they went to the Veterans Administration offices and were granted authorization for examination. They flocked to dental offices. Dentists in good faith completed the clinical and x-ray examinations, filled out the complicated forms to the best of their ability, and hurried the examination forms to the Veterans Administration offices before the expiration of the 30-day period. What then happened is unhappy history. The long wait and the deep silence began.

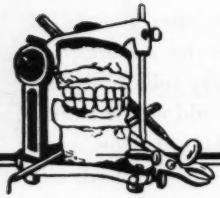
Months, three, six, nine, and more, passed and no authorization for treatment came. The veterans suspected that the dentists of their choice were indifferent and inefficient. No word, not even a postcard, informed the veterans that the delay was the result of bureaucratic bungling and the exhaustion of funds. Neither did any information go out to the participating dentists.

Finally, when authorizations began to be made after months of waiting, many of the veterans had moved, had the service performed at their own expense, or dentists refused treatment on the valid basis that the conditions had changed so much that the cases could not be treated in the manner or for the fee schedules originally planned. How many pulps became needlessly involved and how many teeth were needlessly lost because of delay are facts that will never be known. The veteran, however, has the legal right to demand whatever additional treatment is necessary. This will cost the government additional thousands of dollars, more likely millions.

The defense offered by the Veterans Administration; namely, that the patient demand and patient load were unpredictable, is absurd. Actuarial methods may be applied to evaluate the incidence of dental disease and the need for dental treatment. Such studies have been made and the facts are available. Long-term planning requires that the future dental demands of veterans be evaluated *now*. This is a subject for economists and statisticians to consider in cooperation with dentists. If no long-term plan is formulated the program is bound to be touch and go. The dental needs of veterans must be charted for the next fifty years and the appropriations planned accordingly. The demand for dental care will increase over the years and the presumption is strong that the veterans organizations will demand full medical and dental care for all veterans whether or not their conditions are service connected. We may expect to see *more* rathar than *less* demand for such service in the years ahead.

To clear up some of the present confusion in the dental division of the Veterans Administration, it is hoped that the new Administrator, Carl R. Gray, Jr., will appoint an advisory board of dentists who will sit with him and the present Medical Advisory Committee to plan a long-term dental program. We are all agreed that any program must give good service to the veterans; that it must conserve public funds; that it be administered with efficiency and with proper regard for the traditions of the profession.

Edward J. Ryan



Technique of the Month

Conducted by W. EARLE CRAIG, D.D.S.
Drawings by Dorothy Sterling

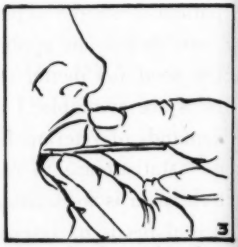
Upper Compound Impression with a Colloid Wash

(An Adaptation of the Niel Technique)

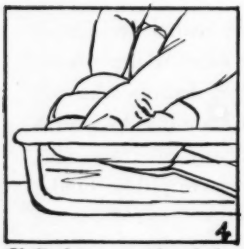
By GLENN WORSTELL, D.D.S.

Select a tray large enough to extend well back of tuberosity, clear frena, and flare outward so that the compound will be thrown toward the mucobuccal fold in some bulk.

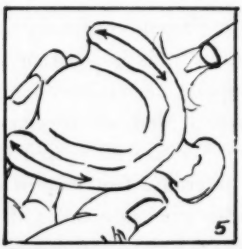
Use two cakes of compound. Impression should be 10 to 12 mm. thick in the palatal region, and 5 mm. thick in the buccolabial region. Bulk of compound is needed for strength and in order to keep alveolar ridge from seating too deeply.



Carry compound to mouth. Gently secure a light imprint to make sure impression is properly centered.



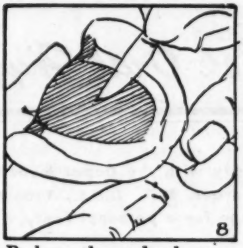
Chill the tray side of the impression in ice water. Carry impression back to the mouth and apply pressure upward. Hold tightly.



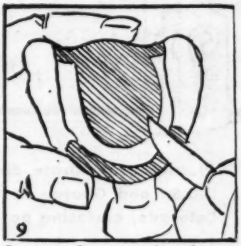
Chill impression and remove it from the tray. Trim excess compound. With hand blowtorch, start muscle correction from the hamular notch to the cuspid region on each side.

Hold the tray firmly in the mouth and, with pressure, pull down the lip muscles. Denture will not be overextended as this is not the final extension of denture. Clear anterior area.

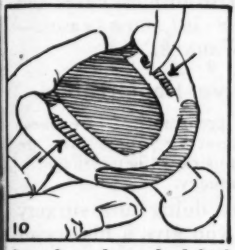
Beginning at the hamular notch on the right side, cut away the compound to a depth of 3 mm. Continue this cut across the postdam area through the hamular notch on the left side.



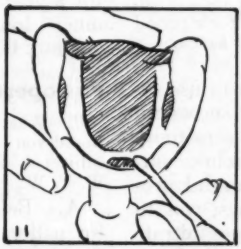
Reduce the palatal area, stopping just short of the ridge.



Lower the peripheral extension previously established, by cutting away 2 mm. or more. Free the labial and any other frena that seem constrained.



Cut buccal and labial flange so that no part of the tray touches the tissue except at the crest of the ridge.



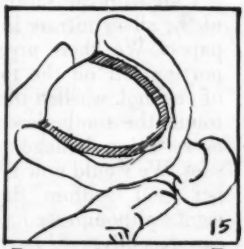
The tray now stands away from the tissue except at the ridge. Scrape the ridge lightly at the median line where the ridge does not tolerate pressure.

Mix a unit of colloid or Zelex slightly thinner than the usual mix. Apply with forefinger to the entire mucobuccal fold, particularly around tuberosity, starting at the hamular notch, working forward.

Place mix on tray, piling up on the periphery rather than on the palate area.

Insert tray in mouth and hold, with no pressure,

with fingers on each tuberosity area. Gently pat lips to shape anterior part of impression. Crest of ridge not trimmed serves as index for tray to seat;



Remove impression. Examine. Compound should show through colloid only on the ridge.

Ask Oral Hygiene

Please communicate directly with the Department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Sensitivity

Q.—I shall appreciate any information you might give me on the treatment of sensitive, exposed dentine areas on the occlusal surface resulting from wear, and of sensitive cervical areas.

I have found that occlusal areas usually lose their sensitiveness after a period of time, but in this case they have not.—G. J. P., California.

A.—Before we began to use sodium fluoride, a rather successful method of overcoming sensitivity on exposed dentine on occlusal surfaces of molars, with careful protection of the soft tissues, was to cover the area with silver nitrate crystals, moisten the crystals, lay a piece of blotting paper over the crystals, and have the patient bite on the blotting paper and hold the mouth closed for at least three minutes. Then when the mouth was opened we lifted the blotting paper off with the saturated solution of the silver nitrate in the blotting paper. We then precipitated the portion left on the tooth with oil of eugenol, washed the mouth, and found the tooth desensitized with no resulting damage to the soft tissues. We would now try the 33-1/3 per cent sodium fluoride treatment,[1] although we have not had a case recently.

I know of no treatment for sensitive cervical areas that will permanently relieve the sensitiveness, although the sodium fluoride treatment will reduce the sensitiveness for a year or so in most cases.—GEORGE R. WARNER.

Postoperative Hemorrhage

Q.—What preoperative treatment would you suggest for patients who are subject to postoperative hemorrhage?—W. T. W., Kentucky.

A.—Before doing any surgery for patients who give a history of postoperative hemorrhage, it is wise to have a thorough blood examination including a record of clotting time. Then, if the physician advises it, have him give preoperative injections of vitamin K.

Excessive Abrasion

Q.—I am sending casts of a patient, a man 33. He is in good general health. His teeth show no caries and there is only a slight irritation of the gingivae. The upper anterior centrals are worn on the lingual side. The laterals were lost because of abrasion causing pulp death and abscesses.

Is there any satisfactory way to lengthen the bite and supply the missing upper teeth with the same appliance? What material should be used, and would it be necessary to cover the palate? If anything can be done, it would be necessary to keep the cost

[1]Bibby, B. G.; and Hoyt, W. H.: Use of Sodium Fluoride for Desensitizing Dentine, J.A.D.A. 30:1372 (September) 1943.

rather low because this patient has a low income.—G. L., Kansas.

A.—At the present time, the simplest and least expensive way to supply the missing laterals and prevent a continuation of the excessive abrasion is to make this young man a full upper acrylic occlusal splint; opening the bite a little short of the relaxed rest position of the mandible.

It should be explained that such a restoration will wear quite rapidly and no doubt have to be replaced, or at least refaced, every year or two or three until your patient can acquire the financial ability to pay you for establishing this corrected occlusion with crowns, inlays, and fixed bridges on both jaws.—V. CLYDE SMEDLEY.

Cervical Decay

Q.—In a past issue of ORAL HYGIENE you stated: "When I see a case of many class V cavities I immediately inquire about the use of chewing gum, for it has been shown that chewing much gum is likely to cause this class of cavities."

I have never found chewing gum to decalcify, but I have seen decalcification and numerous cavities as the result of eating candy.—C. A. S., Maryland.

A.—We have long had our suspicion about the relation of chewing gum to cervical decay, but it remained for an officer in the Army Dental Corps to prove that chewing gum could be in causal relation to decay in these areas.

This officer was stationed in California, and he noticed an unusual number of patients with these cervical cavities. In every case the young man had been employed in an airplane factory where he was not allowed to smoke and therefore had chewed gum. Finally he found a man who had worked in an airplane factory and who had a large number of cervical areas that were decalcified but tobacco stained. This man had chewed gum much of the time when he was not allowed to smoke, but now that he could smoke the carious process had apparently become inactive.—GEORGE R. WARNER.

Storing X-Ray Films

Q.—Perhaps you can explain to me just how an explosion can originate in a stock of x-ray films. An item regarding such an explosion appeared in the April issue of ORAL HYGIENE.[2]—V. B., Minnesota.

A.—Until the last few years x-ray films had a nitrate base which made them, under certain conditions, highly explosive. In 1929 such an explosion and fire occurred in the Crile Clinic in Cleveland with heavy loss of life and property. It was thought that a workman dropped a lighted match or a cigarette.

A laboratory is a poor place to store films. They could be exposed to enough heat to cause them to explode if they were on a nitrate base. Since the Cleveland disaster, films have been made on an acetate base which is not explosive, although it is inflammable.—GEORGE R. WARNER.

"Striped" Enamel

Q.—My assistant presents at various intervals with a peculiar condition involving the incisal half of her six upper anterior teeth. They will become "zebra-striped" from mesial to distal with the stripes appearing like decalcified enamel. The stripes are about one millimeter in width and about one millimeter apart. This condition will remain only for a

[2]X-Ray Film Causes Explosion in Dental Office, ORAL HYGIENE 37:646 (April) 1947.

few hours and then disappear completely for several days. When it is not present her teeth have the appearance of healthy, well-nourished teeth.

There is a slight amount of traumatic occlusion in protrusive. I intend to correct this condition. There is no marked periodontal disturbance. The woman is 27 years of age and married. Her general health is excellent with the exception of periodic inflammation of the ovarian tube on the right side.

Any information as to the cause of this condition and its correction will be appreciated.—E. V. L., Louisiana.

A.—As you know, there is no circulation in tooth enamel. The enamel rods, rod sheaths, and cementing interprismatic substance are fixed when a tooth erupts. It is therefore a remarkable phenomenon for the enamel of teeth to be transversely striped one hour and free from such stripes the next hour. This is such an unusual case it would be most interesting to photograph the teeth when the stripes are visible and when the teeth are free of them. One can often see things in a photograph that are not visible to the eyes.

I am free to say that I have no explanation for the condition. I often eliminate doubtful conditions through the medium of roentgen rays, but I cannot think that roentgen rays would be helpful in this case.—GEORGE R. WARNER.

Immediate Dentures

Q.—I should appreciate it if you would give me your reasons for the insertion of immediate dentures—W. J. C., Massachusetts.

A.—The following are probably not all of the good reasons for immediate dentures:

1. The protection they afford to a person's pride.

2. The fact that the patient's business and social life may be continued without interruption.

3. The maintenance of facial contour and muscle tone and function.

4. Maintaining the normal chin-nose relation and preventing the unnecessary development of wrinkles, sagging tissue, and jowls.

5. Preventing nerve pressure or other injury to the mandibular joint or impingement on and closure of the Eustachian tube, with impairment of hearing, head noises such as roaring, snapping or hissing sounds, or intense pain.

6. Man is the most adaptable being on earth, and it is Nature's constant endeavor to conform herself to the environment and task that are put upon her. I, therefore, believe that a better ridge is likely to result under an immediate denture which is worn during the entire period while Nature is filling in the sockets with new bone and forming a ridge.

7. Last, and perhaps least important, a better fee is justifiable for immediate denture service for two reasons: it requires more time, patience, and skill to make, place, and service the dentures; they are worth more to the patient, and most patients appreciate the fact and are willing to pay extra for the additional benefit and satisfaction which they enjoy.—V. CLYDE SMEDLEY.

Hydrochloric Acid

Q.—I have a patient who has been taking hydrochloric acid for a period of six years.

The patient takes excellent care of her teeth, but in the last two years she has had numerous cavities. She takes the hydrochloric acid much diluted and

through a straw, using soda water after the acid.

I shall appreciate any suggestion you have to offer that will decrease the caries.—W. B. E., Alabama.

A.—In my experience hydrochloric acid taken for medicinal purposes is not in causal relation to caries. If as much as fifteen drops of dilute hydrochloric acid, diluted in an eight-ounce glass of water, is taken before, during, or after meals, over any considerable length of time, there will be some loss of enamel. Taking the acid through a sipper is of no protective value. In at least one case I found that the lingual surfaces of the anterior maxillary teeth were denuded of enamel after taking the acid through a sipper for six months. When the acid is taken through a sipper the tongue holds it against the lingual surfaces of these maxillary teeth.

We have had several cases in which the labial enamel of the anterior maxillary teeth was destroyed by the daily use of lemon juice in a cup of water. Stafne and Lovestedt[3] have written on this subject recently.

The caries of which you speak may result from too much sugar in one form or another in the diet or between meals. Without a more intimate knowledge of the case, I could not offer any other suggestions except to have a bacillus acidophilus count made. If the count is high, you can assume that the carbohydrate intake is probably too high.—GEORGE R. WARNER.

[3]Stafne, E. C.; and Lovestedt, S. A.: Dissolution of Tooth Substance by Lemon Juice, Acid Beverages and Acid from Some Other Sources, J.A.D.A. 34:586 (May 1) 1947.

Viscosity of Saliva

Q.—Is there any successful method of correcting the viscous saliva found in some young patients 16 to 25 years of age? I do not necessarily mean the type who has a bountiful flow of saliva, but rather the type whose saliva is so thick that it is even difficult to render a thorough prophylaxis. Such a mouth always presents an unclean appearance and usually extensive caries. I have seen some who even choke up on their own saliva.

If possible, dental treatment in these cases should begin with saliva control. Are there any drugs or any treatment that can be used to effect such a change?—R. L. S., Pennsylvania.

A.—Viscosity of the saliva can be corrected and controlled through diet. Have such a patient eliminate all carbohydrate foods until the saliva becomes normally fluid. This may take several days. After this the amount of carbohydrate foods taken can be regulated in accordance with what is necessary to maintain a normally fluid saliva.—V. CLYDE SMEDLEY.

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

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With sudden fury and tremendous violence, the great earthquake of 1906 struck San Francisco, shook it tumultuously, crashed down an avalanche of destruction. Followed by the ravaging flames of uncontrolled fire, the city was laid waste—an awe-inspiring though devastating scene of disaster caused by the unavoidable forces of Nature . . .

Uncontrollable and unavoidable variations in amalgam technic are likewise detrimental to the physical properties of the material. Cavities vary in size and accessibility, mixes and manipulations are never the same, no two operators work exactly alike . . .

Alloy-wise dentists overcome these variables by using MINIMAX ALLOY No. 178—the alloy that is fabricated to allow wide leeway in manipulation and still make amalgam that complies with all specifications. Experience the pleasure of working with an alloy that minimizes the variations that occur in every day procedure. Use Minimax with confidence and success.

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Laffodontia

The wonderful love of a beautiful maid,
The love of a staunch, true man
And the love of a baby—unafraid
Have existed since life began.
But the greatest love—the love of loves,
Even greater than that of a mother,
Is the tender, passionate, infinite love
Of one drunken bum for another.

★

She took my hand with loving care,
She took my costly flowers so rare,
She took my candy and my books,
She took my eye with meaning looks,
She took all that I could buy,
And then she took the other guy.

★

He: "Will you ever forget that glorious week end at Atlantic City?"

She: "Well, what am I offered?"

★

Voter: "I wouldn't vote for you if you were St. Peter himself."

Candidate: "If I were St. Peter you couldn't vote for me. You would not be in my district."

★

"What time is it?"

"I don't know. I left my watch upstairs."

"Aren't you afraid it will run down?"

"Naw, we got winding stairs."

★

Pro: "Sure golf is easy. All you do is smack the pill and then walk."

Co-ed: "Oh, just like some auto rides I've been on."

★

First Hillbilly: "Yes, sir, my gran' pappy lived to be 90 and never used glasses."

Second Hillbilly: "Mine, too, he allers drunk from thu bottl'."

And we heard a story about a local woman who purchased fancy underwear to wear when examined by her doctor.

She was indignant because all the doctor looked at was her tongue.

★

Cook: "Can you dress a chicken?"

Boot: "Not on the money the Navy is paying me."

★

Native: "Sahib, I saw a lot of tiger tracks a mile north of here."

Hunter: "Good. Which way is south?"

★

A firm wrote the following letter to the War Manpower Board:

"We shall be glad if you can assist us in retaining this man a little longer. He is the only man left in the firm, and is carrying on with fifteen girls."

★

Private: "I bought her a fine dinner, took her to the best show in town, then to a night club, and do you know what she said?"

Corporal: "No."

Private: "Oh, you've been out with her, too?"

★

Patient (recovering from operation): "Why are all the blinds drawn, Doctor?"

Doctor: "Well, there's a fire across the street, and I didn't want you to wake up and think the operation was a failure."

★

Sweet Young Thing: "What's the trouble, officer?"

Traffic Cop: "You were going sixty miles an hour, Miss."

S. Y. T.: "Ah, that's where I've got you. I've been out only ten minutes."

"MY PET PATIENT," says Dr. G. H. L., "is a cross-word puzzle enthusiast. She can tell you the symbol for erbium in two letters and a three-letter word meaning bitter vetch without batting an eye.

"She's pretty good at seven-letter words, too. When I mentioned the foaming detergent solution that rapidly kills most bacteria common to the oral cavity, and yet is safe for everyday oral hygiene, she said:

"'That's Cēpacol—famous for refreshing flavor!'"

She chewe

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BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

Du Pon

on tacks for the rest of her life

WHEN this Japanese woman of long ago los all her upper teeth, the dentist carved plate of thin, light wood. He hammered in tw rows of metal tacks, leaving the heads exposed These were placed toward the rear to facilitat chewing. We don't know if splinters bothere her, but at least she was able to chew.*

Although it was a helpful substitute for missing teeth at tha time, this plate was a far cry from the excellent dentures being wor today. In recent times scientific dentists, working with carefully de veloped equipment and materials, have continually improved den tures and discovered a whole new world of dental techniques. The result—today's high level of skill in dentistry.

To meet the exacting requirements of modern prosthetic dentistry, Du Pont research developed "Lucitone" acrylic resin denture mate rial. Continuous research and manufacturing experience, allied with dental know-how, make "Lucitone" a standard of excellence in denture material . . . a combination of the most desired qualities for laboratory, dentist and patient.

**From "History of Dentistry," by J. A. Taylor, D. D. S.*

WHY DENTISTS CHOOSE "LUCITONE" DENTURES:

Naturally lifelike—translucent.

Pure—contain only the finest material.

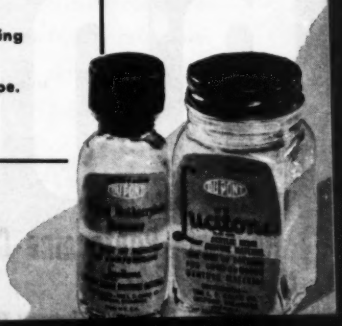
Strong—resist sudden blows and falls.

Odorless and tasteless—pleasant to wear.

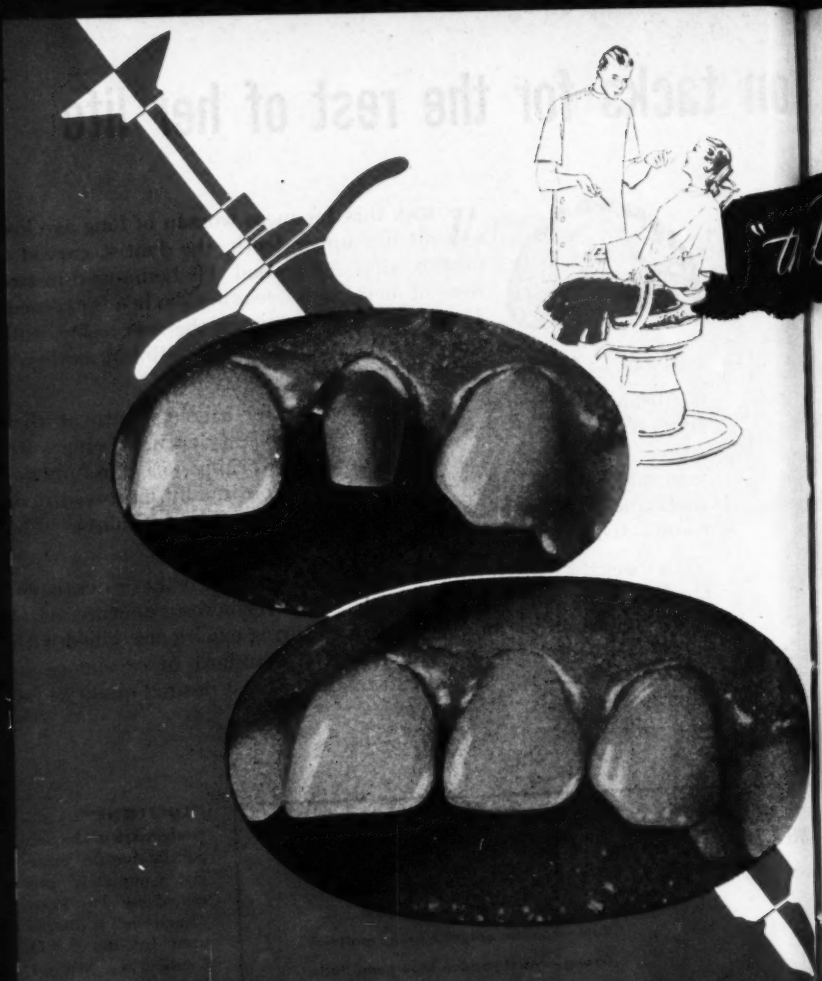
Abrasion-resistant—resist scratching and pitting.

Dimensionally stable—retain shape.

"LUCITONE" is the trade mark of the only acrylic denture material completely processed by Du Pont. "Lucitone" is distributed by the L. D. Caulk Co., Milford, Delaware.



n Lucitone"



npc

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but what has "N.P.C." to do with the beauty of a porcelain jacket crown restoration?

Years before use of Novocain-Pontocaine-Cobefrin became routine in operative procedures, one of the old masters of porcelain jacket crown work, in describing his preparatory technique, wrote:

"The first step, *after the patient has been properly anesthetized,* . . . is to reduce the length of the tooth by removing the incisal enamel."

"*After the patient has been properly anesthetized*" — note that. Even in those days, when patients were expected to "take it," this dentist realized that for a perfect preparation and a perfect restoration he needed time and a calm, relaxed patient.

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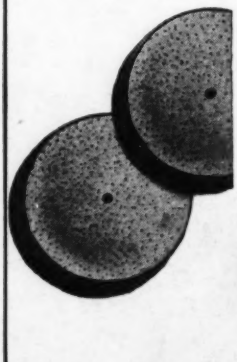

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YOUR HIGHEST SKILL may be offset almost overnight by changing tissues; by tender spots and irritations that wreck patient cooperation . . . with resultant dissatisfaction and loss of valuable chair time on frequent and sometimes futile adjustments.

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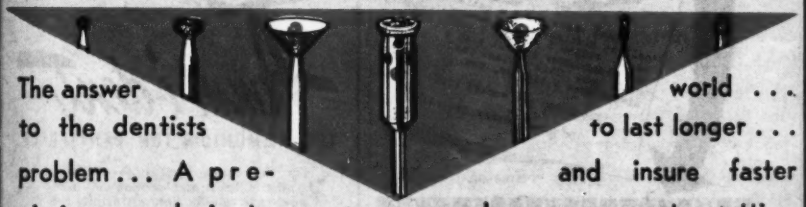

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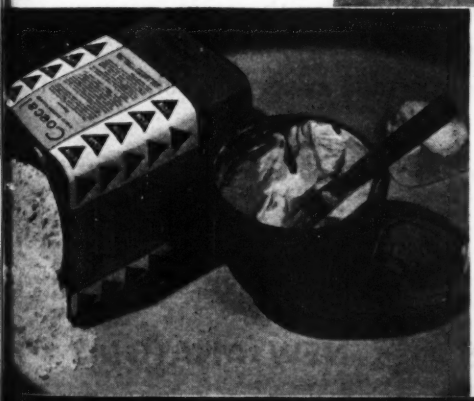

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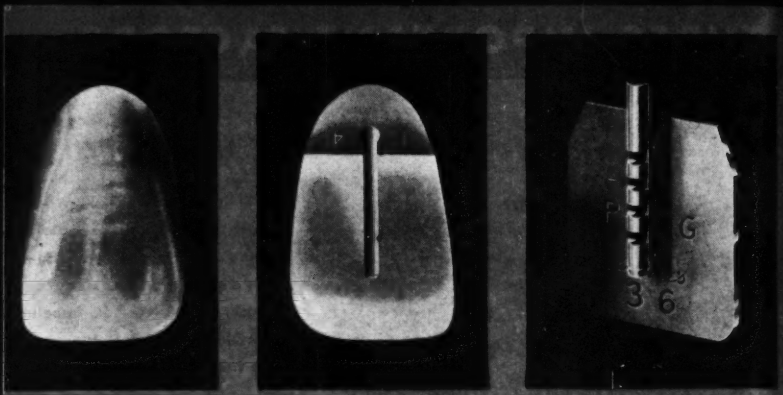

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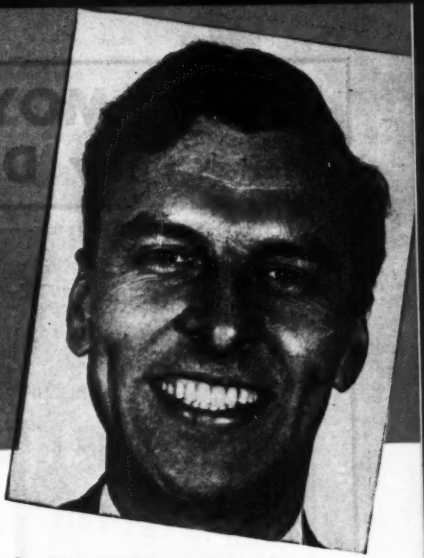

Not a photographer's model but an actual dental patient. Lost upper centrals, laterals and three bicuspids restored. Name of Dentist on request.

. . . ENTIRELY *New* ESTHETICALLY

signed that they act as *facets* when wet with saliva, creating tiny shifting highlights that impart a "live tooth" sparkle. This feature gives New Hue porcelain the glow and living appearance of natural teeth.

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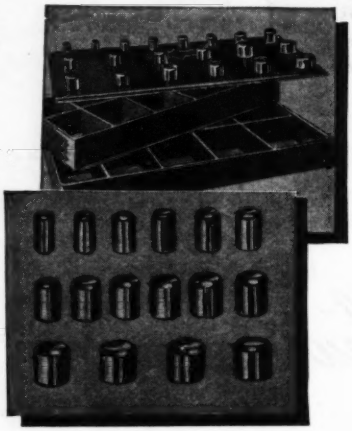

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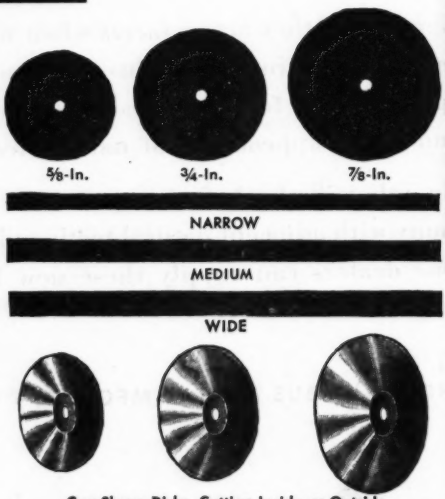

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BIBLIOGRAPHY . . . (1) Gottlieb B., Diamond M. and Applebaum E., Am. Jr. of Orthodontics & Oral Surg., V 32, No. 6, P 365-379, June 1946. (2) Gottlieb B., Ztschr. f. Stomatol, 19: 129, 1921. (3) Gottlieb B. and Hinds E., Jr. Dent. Res. 21, 317, 1942. (4) Younger H., Freeman Clinic for Children, Dallas, Tex. (5) Frisbie, H. E. and Nuckolls, J., Jr. Dent. Res., 26: 181, 1947.

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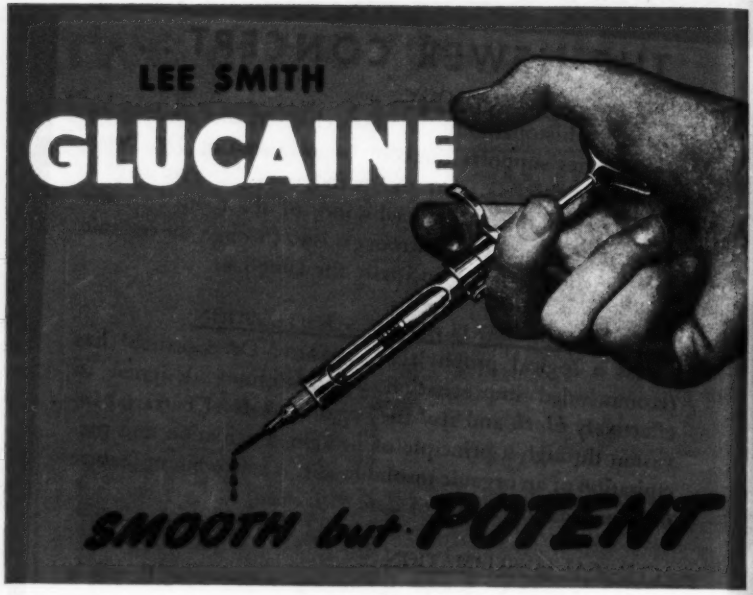

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Study models show patients their mouths as you see them. Make study models regularly. You need them as you do X-Rays.

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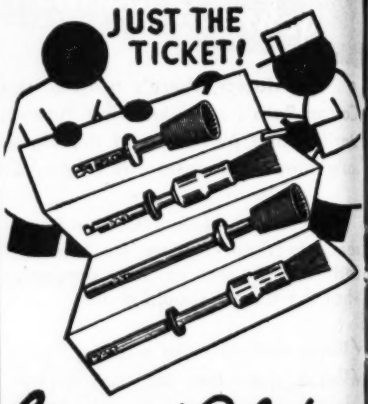

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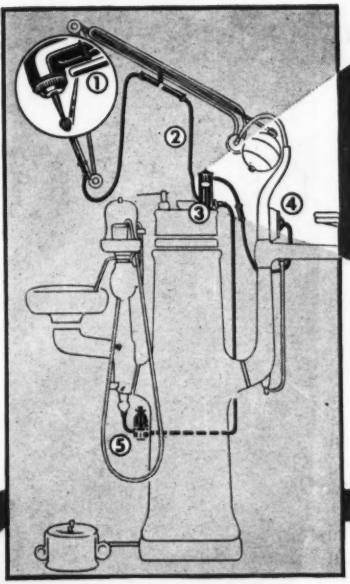

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THE ORIGINAL HENSCHEL AUTOMATIC

Thermal control unit

FOR WATER . . . OR AIR . . . OR BOTH TOGETHER

Note These Features!

1. EXCLUSIVE PATENTED TWIN TAPE-TUBE . . . Slender, streamlined nozzle attachments fit standard contrangles, handpieces. Easily held, perfectly balanced. 2. SLENDER OUT-OF-THE-WAY TUBING . . . Kept out of the way by ingenious forearm attachment; follows armpiece. 3. HEATER RESERVOIR . . . (See above). 4. SIMPLE ELECTRICAL INSTALLATION . . . Automatically synchronizes water flow with engine operation. Constant, unfailing. Yet, for operating dry, polishing — a flick of the switch and it's off! 5. SIMPLE WATER CONNECTION . . . Nothing to fill, no annoyance of running dry. Pressure easily, accurately controlled. Filters easily removed, cleaned, replaced. No spray, no fogged mirrors. AIR manually controlled.

FOR THE BEST IN THERMAL CONTROL, USE THE HENSCHEL THERMAL CONTROL UNIT . . . RESULT OF OVER 10 YEARS OF AT-THE-CHAIR DEVELOPMENT AND USE.

NOW AVAILABLE FOR IMMEDIATE DELIVERY
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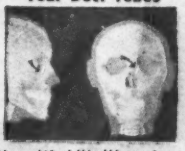
Makers of Amm-i-dent . . . The Ammonium Ion Dentifrice

THE THERMAL CONTROL UNIT FOR PAIN CONTROL • AMM-I-DENT FOR CARIES CONTROL

NEWS AND VIEWS OF VITALLIUM

Tear Duct Tubes



Now it's Vitallium tear duct tubes! More properly they are called naso-lacrimal duct tubes and are placed in the head to maintain drainage from the eye into the nasal passages. As a result of a head cold, it may happen that the tear ducts which drain the tear sacs become clogged. This means either cutting through the nasal bones to relieve the congestion, or inserting a Vitallium tube. Silver tubes had been used, but often disintegrated or caused tissue reaction. Vitallium tubes, however, cause no reaction and have been used with success by many ophthalmologists since they were reported in medical literature by Dr. W. E. Muldoon in December 1945.

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It is as if you wrote the prescription. Vitallium dentures are clean, bright and lustrous at all times. The hardness of the Vitallium alloy is your assurance of these qualities. The surface is dense, smooth. Tastes and odors are not absorbed. Food pockets do not accumulate. It is easy to keep a Vitallium denture clean. VITALLIUM for modern dentistry.

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- Vitalon Denture and Bridge Resin
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$5.50 ea. Simpson's Queen Anne Sanforized Poplin, 3 for $15.80

$4.25 ea. Indian Head Suiting, Sanforized Shrunk 3 for $12.10

Illustrated here is one of the many Ready-to-Wear styles designed for good appearance, comfort, action; in two nationally advertised quality materials; Scovill rust- and laundry-proof Gripper fasteners.

For details of other styles of this line, send for Catalog OD-1.

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Quality in workmanship and materials give the wearers of Pa-Kay uniforms a well-groomed professional appearance.

Pa-Kay uniforms

One of the Ready-to-Wear models which combines crisp, neat appearance with comfort and free movement.

Made of Simpson's white combed poplin or of white Koda Doagonal (Rayon).

STYLE 208

$6.95 ea.

Sizes 10-42

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...ufactured to comply with ...D. A. Specification 12

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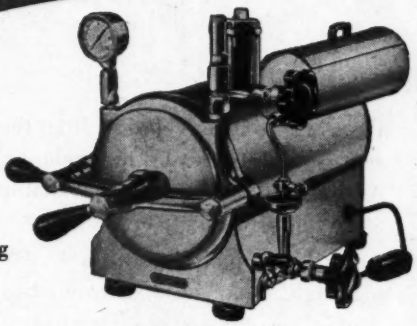

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Help your patients help themselves to better oral hygiene – specify the

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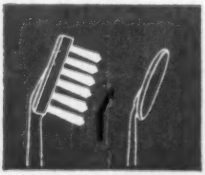

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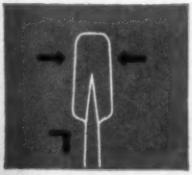
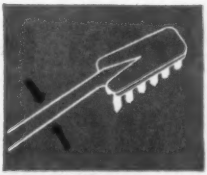


JOG ANGLE
SMALL HEAD



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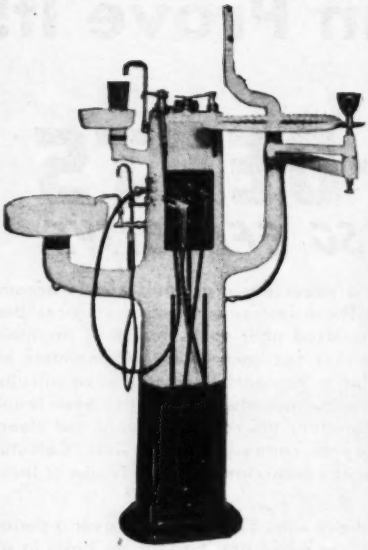

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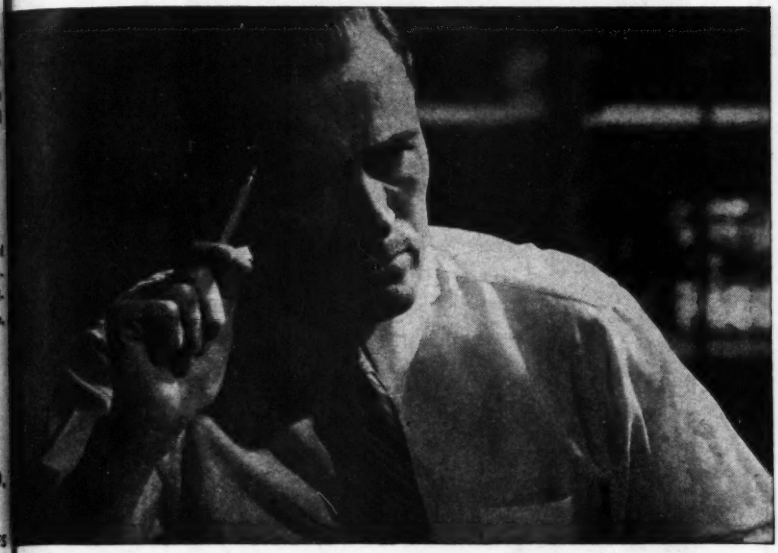

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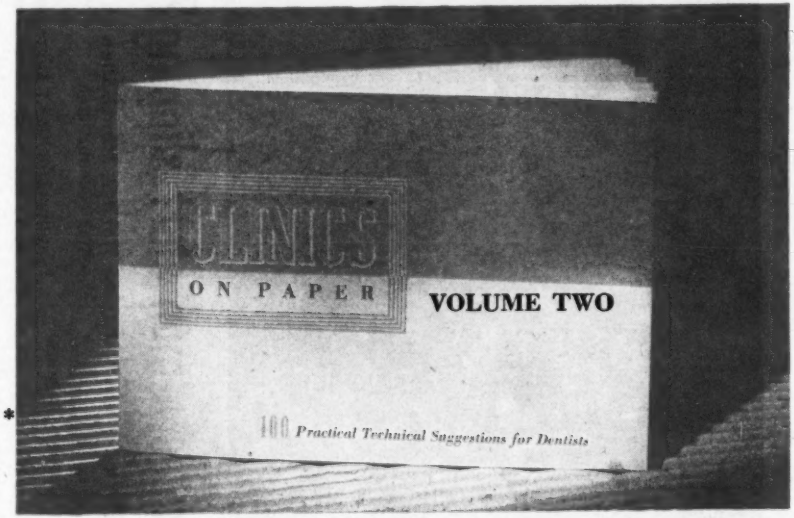
A typical comment .

"It's too bad every dentist does not know of this



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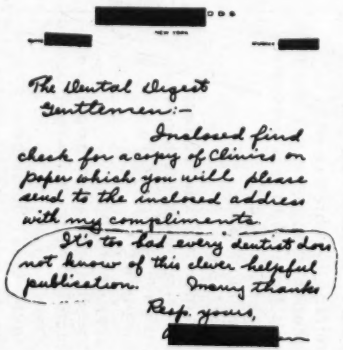
A TYPICAL LETTER . . .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The Dental Digest
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Inclosed find check for a copy of Clinics on Paper which you will please send to the inclosed address with my compliments.

It's too bad every dentist does not know of this clever helpful publication. Many thanks

Resp. yours,
[redacted]

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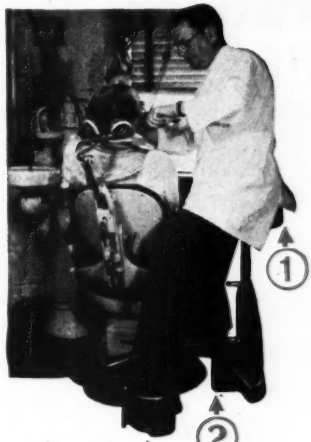

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Patent applied for

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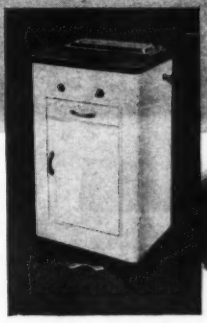

MODEL DB is available in White, Cream-white, Neptune green, Jade green, Ivory-tan and Black. Exterior dimensions are 33¾" wide, 13" deep and 35" high.

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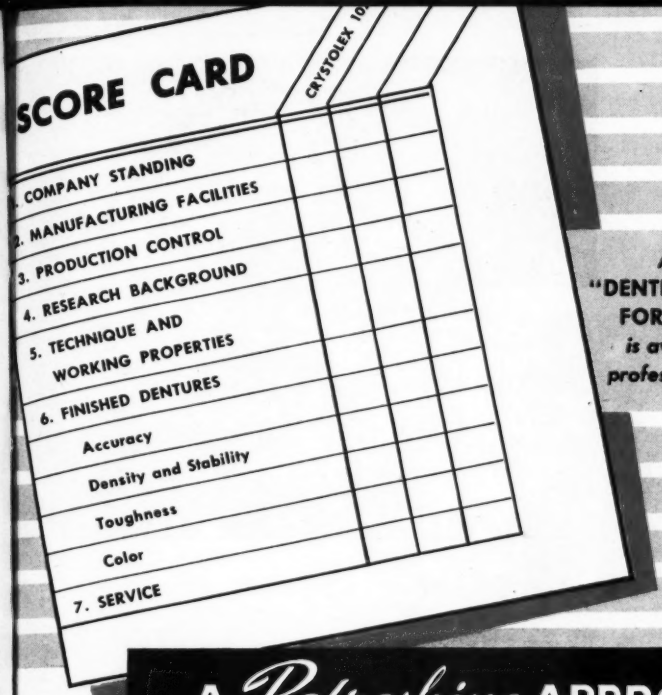

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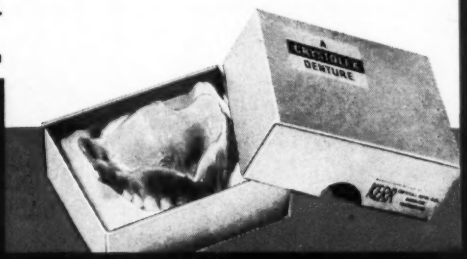

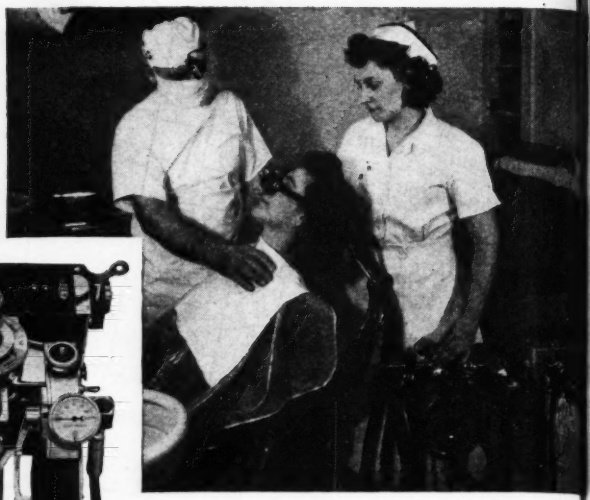

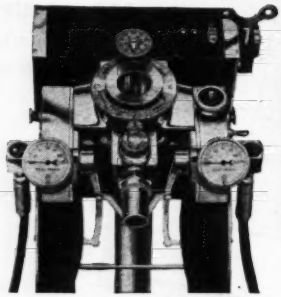

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THE "BEFOREHAND" LOTION

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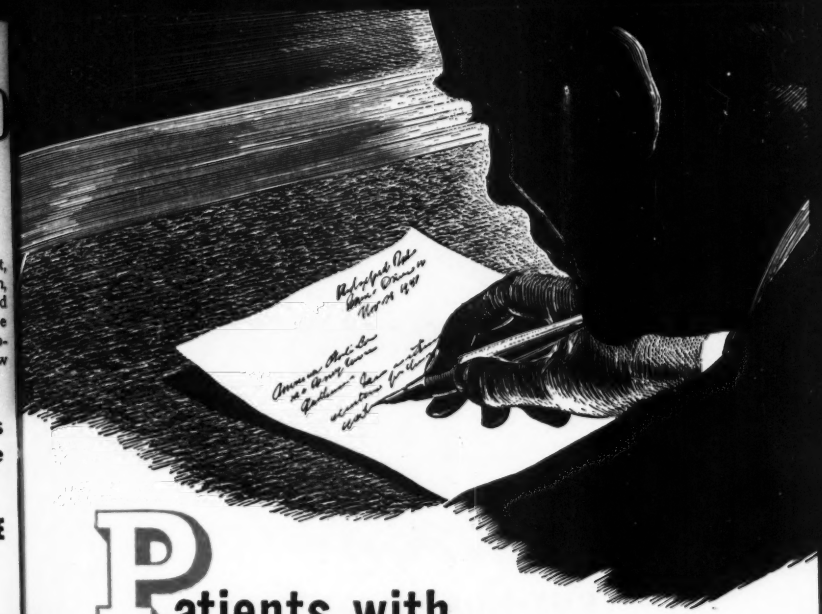
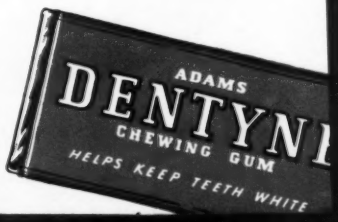


Patients with acrylic dentures tell us...

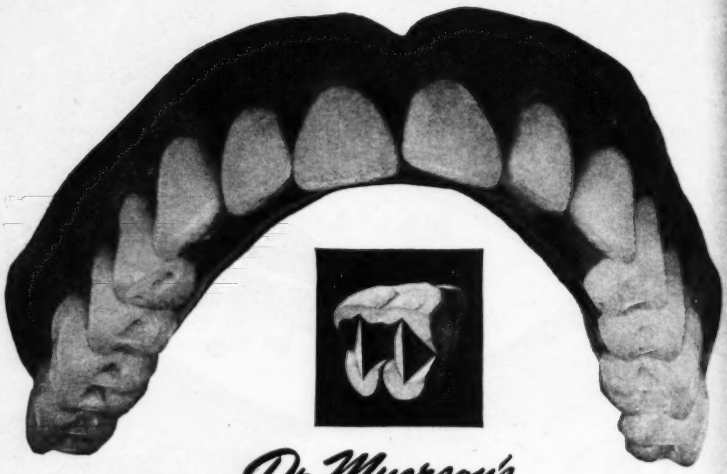
Numerous unsolicited letters which we receive from patients with acrylic denture restorations contain an interesting observation which may be of value to you. These people tell us they are delighted to discover in Dentyne a gum which they can chew even after they have been fitted with acrylic dentures.

The gist of their letters is that Dentyne Gum has a distinct advantage because it does not adhere to their acrylic dentures. Consequently, more patients can enjoy the benefits and pleasure incident to chewing Dentyne Gum without any discomfort or annoyance.

Since its delicious long-lasting flavor renders it pleasurably acceptable, you may wish to recommend Dentyne to your denture and other patients.



DENTYNE
CHEWING GUM
the ideal masticatory

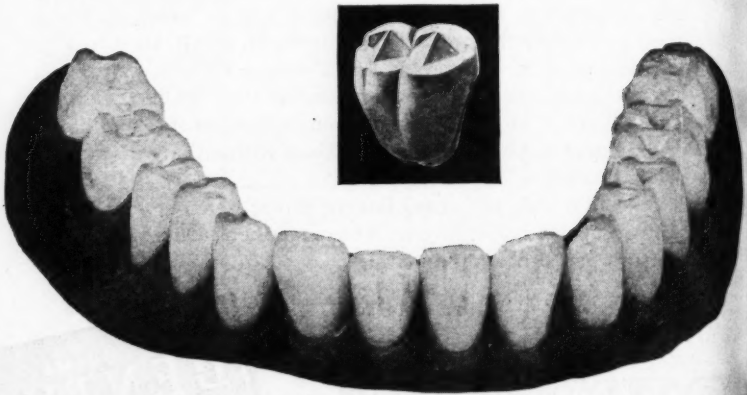


Dr. Myerson's

TRUE-KUSP POSTERIORS

TRUE-KUSP'S superior efficiency is the result of SIX exclusive features. . . .
1. Sharp wedge-cutters for easy cutting of food. 2. Flat milling surfaces for thorough mastication. 3. Adequate clearances to prevent clogging. 4. Non-interfering lateral motion. 5. Aesthetic effect — resemble worn, natural teeth. 6. AND THEY ARE STRONGER!

Use Dr. Myerson's True-Kusp with True-Blend, Characterized or Modern-Blend anteriors for greater patient satisfaction.



MYERSON TOOTH CORPORATION • CAMBRIDGE 39, MASS.

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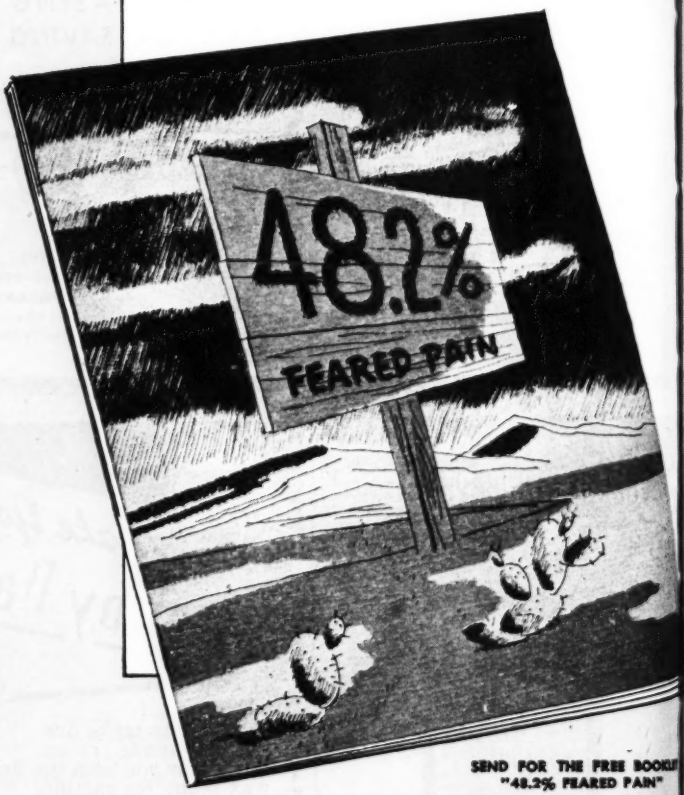
What Happens



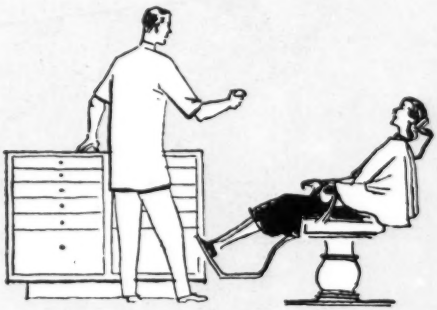
SEND FOR THE FREE BOOKLE
"48.2% FEARED PAIN"

It's a comprehensive, well documen
ed review of some of the new
medical aspects of pain preventio
and control having *practical* app
cation in Dentistry.

when 48.2% fear pain?

They dodge proper dental care . . . just as did 48.2% of the adult citizens of Oklahoma City![1]

This figure impressively highlights Anacin's importance in dentistry.



Take full advantage of Anacin's proven efficacy—use it *before* chair-time to help allay anxiety . . . use it *after* chair-time to help preclude postoperative pain.

If you haven't yet requested Anacin's Free Monthly Service, do so today. Just drop a note on your letterhead to the Whitehall Pharmacal Company, 22 East 40th Street, New York 16, N.Y.

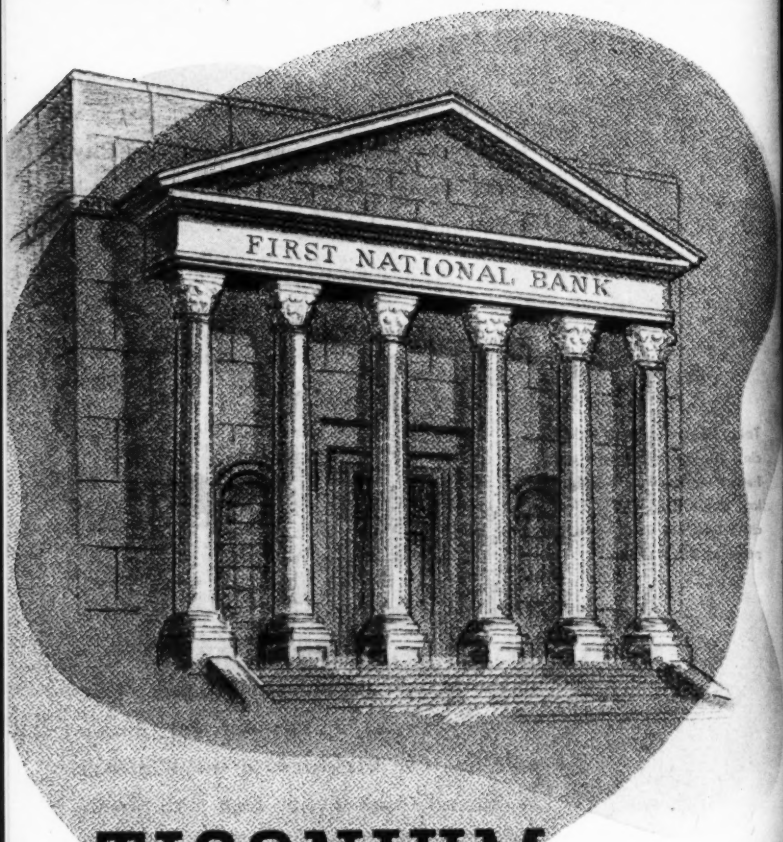
ANACIN

REG. U.S. PAT. OFF.

Dentistry's Choice 2 to 1

[1] The Bulletin of the Oklahoma State Dental Society. 30, No. 2 (1941)

TICONIUM

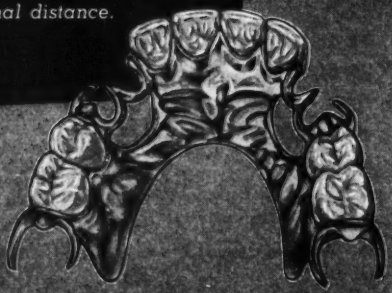


TICONIUM
IS
DEPENDABLE

POSSESSES

- ACCURACY
- BEAUTY
- LIGHTNESS
- STRENGTH

BEAUTY . . . that has none of the garrish shine to make a partial denture conspicuous, but beauty gained through the soft, shiny color of burnished platinum to harmonize with oral tissue. *A Ticonium case is scarcely detectable at conversational distance.*



TICONIUM

413 North Pearl Street, Albany 1, N. Y.

Announcing

P.N.3.

FEATURES:

- **Profound anesthesia lasting from 1 to 1½ hours.**
- **Uses least toxic of all vaso-constrictors.**
- **Perfectly balanced concentration of Procaine Hydrochloride.**
- **Onset of anesthesia almost immediate.**
- **Excellent patient reaction—cardiac output least affected—reduces operative and post-operative nervousness, perspiration, fainting and tremor.**

PROCAINE HYDROCHLORIDE 3%
WITH NEO-SYNEPHRINE 1:2500

Each C.C. Contains

Procaine Hydrochloride	0.03 gram
Neo-Synephrine	0.0004 gm
Sodium Thiosulphate (Anhydrous)	0.001 gram
Sodium Bisulfite	0.0007 gm
Sodium Chloride	0.002 gram

IN DISTILLED WATER

new

new

a new formula

This new Proco-sol anesthetic was successfully formulated to fill a much needed requirement in dental anesthesia.

It offers a perfectly balanced Procaine concentration—with the *least toxic* of all vaso-constrictors—it assures profound, dense anesthesia lasting from one to one and one-half hours—it is compatable to the tissues.

Patient reaction has been found to be excellent, without exception . . . with marked reduction in nervousness, fainting, perspiration and tremor. No untoward reaction is evidenced in cardiac output.

The onset of Proco-sol P.N. 3 is almost immediate. The ample operating time allowed therefore indicates its specially desirable application for porcelain and acrylic jacket preparations which involve areas of high sensitivity.

Your Proco-sol Dealer has already received his stock of Proco-sol P.N. 3. You may order it for immediate delivery.

*Neo-Synephrine is the registered trade mark of Sterling Drug, Inc. and identifies its brand of phenylephrine, which is contained in this solution.

Proco-Sol

CHEMICAL COMPANY, INC.
5742 MARKET STREET • PHILA. 39, PA.

A large percentage of the nation's dentists recommend Revelation Tooth Powder. This fact is indicated by surveys in many parts of the country. Cleans teeth safely, thoroughly, pleasantly. We invite you to test it at our expense. *Please include professional stationery with your request for samples.*

A NATIONAL FAVORITE
FOR OVER FORTY YEARS

REVELATION TOOTH POWDER

AUGUST E. DRUCKER CO., 2226 BUSH ST., SAN FRANCISCO 15

( ) Send full size can for personal trial.

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OH-1-48

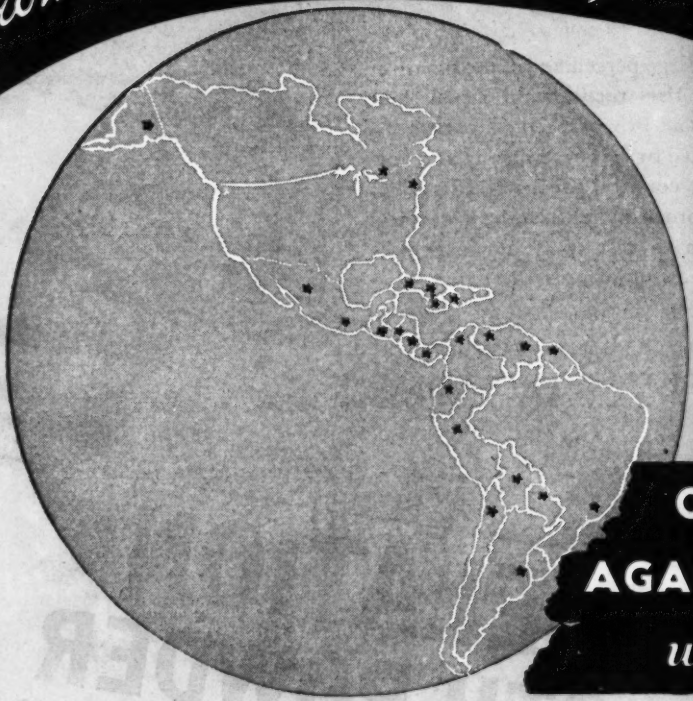
Dr._____

Address_____

City_____ Zone___ State_____

ALL METAL CANS

From the Halls of Montezum to



O NU
AGAIN A
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Monocaine is supplied in Metal Cap Anestubes which may be flamed to assure asepsis of the puncturable diaphragm of the cartridge. Monocaine bears the seal of acceptance of the American Dental Association and the American Medical Association.

EACH STAR (★) REPRESENTS A MANUFACTURING PLANT DEVOTED TO THE MANUFACTURE OF NOVOL LOCAL ANESTHETIC PRODUCTS OR A PRIME DISTRIBUTOR AIDING IN THE BLACKOUT OF PAIN WITH MONOCAINE

ACCEPTED
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* Monocaine is the registered trade of the Novocol Chemical Mfg. Co.

"All ingredients in FASTEETH meet the official United States drug standards for purity and quality."
Gum Karaya N.F. VIII, Sodium Borate U.S.P., Oil of Peppermint U.S.P.

DENTURE PATIENTS DON'T COME BACK

A recent survey shows that only 33.2% of all denture wearers ever find their way back to a dental office. Apparently, when normal resorption occurs patients do not realize that this condition demands their dentist's assistance.

Many dentists believe that adequate instruction at the chair will eventually correct this attitude. In the belief that pictures speak stronger than words the brochure "Denture Closeups" was developed. It describes graphically the story of tissue resorption and "when mouth tissues change—see your dentist."

Write for your free copy of "Denture Closeups" today.

FASTEETH

CLARK-CLEVELAND, INC. OH-1

Binghamton, N. Y.

Gentlemen: Please send brochure, "Denture Closeups."

Dr. _____

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10c per word, initials and figures used each counting as one word. Please send remittance with your order.

WANT ADS

Restricted to help wanted, positions wanted, practices wanted, practices for sale. The minimum charge is $1.

Established high-class laboratory in Texas wants A-1, all around technician, from set up to finish, to crown and bridge work. Must have fine background to take charge of a branch laboratory in Texas on a commission basis. High monthly salary guaranteed. Only high type man looking for future security need apply. "405" Oral Hygiene, Pittsburgh, Pa.

WANTED: A dentist to work for fifty percent of the cash he takes in; he must furnish his own instruments and contra angles; all other equipment and expense will be taken care of by myself. Will be willing to sell by June, 1948. Option to buy will be given consideration. Location, northern Wisconsin. "406" Oral Hygiene, Pittsburgh, Pa.

A-1 ALL AROUND LAB MAN would like to open a one man lab in a small town in a dry climate. Any town interested? "407" Oral Hygiene, Pittsburgh, Pa.

OFFICE SPACE—Approximately 400 sq. ft. specially designed for dentist's office, accommodates two chairs, lab, D-room, reception room and office. Located in thriving suburb of Denver. New building, hot water heat. Denver telephone rates, plenty parking space. Write or wire agent, Ben E. Dunlap, Arvada, Colorado. Telephone GRand 4244 or Arvada 50.

GOLD MAN on both fixed and partials with full knowledge of chrome from start to finish desires to locate in midwest. Twenty-five years' experience. "408" Oral Hygiene, Pittsburgh, Pa.

It is with pride that I offer my excellent dental practice in Washington state. This year-round income community will not feel the next depression; wheat, alfalfa, livestock and lumbering; good fishing and hunting. Virtual dental monopoly; big city fees with small town advantages. Two chairs, units, General Electric x-ray, Castle lighting, etc. Best opportunity in Washington. Full price, $4500. Must be sold in three months. "409" Oral Hygiene, Pittsburgh, Pa.

EXPERIENCED DENTIST REGISTERED in Pennsylvania wants proposition or partnership. Can make investment with services, or consider renting or buying established practice. "410" Oral Hygiene, Pittsburgh, Pa.

WANTED: Dentist in an Oklahoma city wants associate in his two-chair office. This is an excellent opportunity for a good man. "411" Oral Hygiene, Pittsburgh, Pa.

EXPERIENCED all-around technician by dental laboratory located in progressive northern New York town. "412" Oral Hygiene, Pittsburgh, Pa.

WANTED: Dentist; five-room suite Medical Building, San Fernando valley. Well equipped but must share reception room with established doctor. Dentist retiring. Rent—$100 monthly. Mrs. Dorothy F. Bradley, 204 South Venice Blvd., Venice, Calif.

FOR SALE: Modern dental laboratory, fully equipped; located in Washington state. Established business. Opportunity for A-1 technician. $7500 cash or terms. Owner retiring. Can show clean set of books. "413" Oral Hygiene, Pittsburgh, Pa.

FOR SALE: Due to death, unopposed dental practice established 36 years in Northwestern Iowa town. Office in local hospital. Newest equipment. Write Marjorie R. Ball, Box 547, Battle Creek, Iowa.

FOR SALE: Dental practice, established in good location in Pittsburgh, Pa. area. "414" Oral Hygiene, Pittsburgh, Pa.

FOR SALE: Due to death, Florida practice in large city; established twenty years. Good industrial and agricultural center. Three chairs, gas machines, air compressor and large fully equipped laboratory. "415" Oral Hygiene, Pittsburgh, Pa.

SELLING YOUR PRACTICE? Why not also use the classified columns of The Dental Students' Magazine. National circulation 10,200 monthly. This includes over 3,000 recent dental graduates (U.S.A. and Canada). Many of these readers are looking for an opportunity such as you have to offer. Our rates, $2.50 for 50 words or less, 1c per word additional; check with order. Write Dental Students' Magazine, 605 N. Michigan Ave., Chicago 11, Ill.

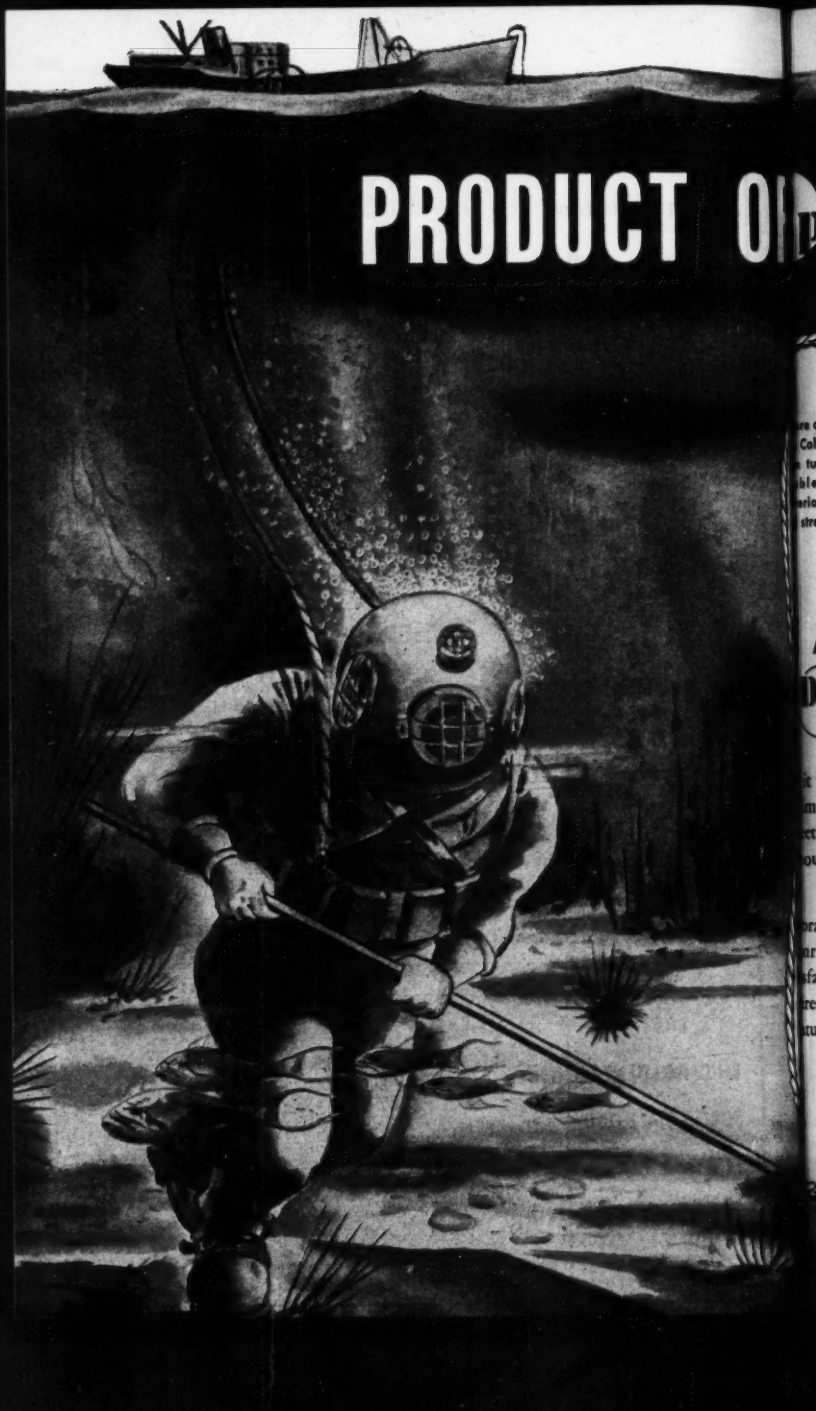
FOR SALE, RENT, or a dentist to work on commission. I have to retire on account of age, health and eyesight. Located in good town in North Dakota. "416" Oral Hygiene, Pittsburgh, Pa.

FOR SALE: Thriving business, well equipped two-chair office; one new SSW Unit, one Electro Dental Unit Air Compressor, Pelton sterilizer, all Castle lighting system. Low operating expense. Population twenty-five thousand. Located in Massachusetts and is wonderful opportunity for young man. Owner retiring. "417" Oral Hygiene, Pittsburgh, Pa.

WANTED: Established practice or association with option to buy; New York or New Jersey. Is young experienced practitioner, "418" Oral Hygiene, Pittsburgh, Pa.

FOR SALE: Dental office, Grand Concourse, Bronx, New York. Completely furnished. New equipment; Ritter Senior Unit, Motor chair, Mobile x-ray, Castle sterilizer, etc. Rent very reasonable. Long lease obtainable. Leaving city. "419" Oral Hygiene, Pittsburgh, Pa.

FOR SALE: Practice established forty-five years in busy country town in New Jersey. Agricultural section. Retiring due to advancing age and health. Reasonably priced. "420" Oral Hygiene, Pittsburgh, Pa.


PRODUCT OI

MARINE RESEARCH

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Colloid removed
tube and bent
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erial's pliability
strength.

Packaged in metal tube which allows any portion of the contents to be used and the balance preserved.

AMAZINGLY PLIABLE D-P IMPRESSION COLLOID

The illustration above is an actual photograph—it proves conclusively that D-P IMPRESSION COLLOID can be used impressions which include the most severe undercuts and angulations eth imaginable and that it can be removed from such undercut areas out breaking or even suffering the slightest distortion.

As a result of prolonged and continuing research in our Marine oratory, plus rigid laboratory controls, D-P IMPRESSION COLLOID nrivalled for strength, toughness and elasticity—and for uniformly factory performance. It is extremely accurate for Partial, Full and rect Inlay Impressions. It needs no mixing, is usable at near body temture and gives an improved set on all stones and investments.

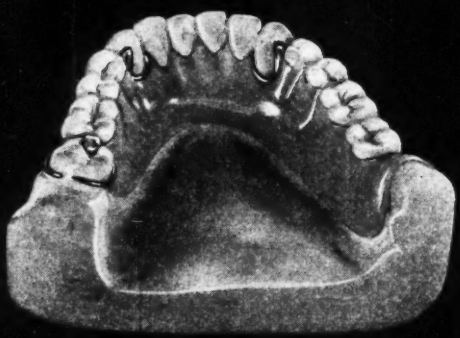
FOR BEST RESULTS—ALWAYS FOLLOW DIRECTIONS

One of the D-P PRODUCTS FOR PROGRESSIVE DENTISTRY.

DENTAL PERFECTION CO.
543 West Arden Avenue
Glendale 3, California

Densene "33"...

for your resi



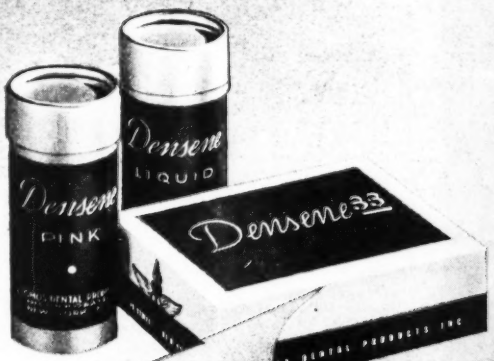
The accuracy of Densene "33" permits precision molding! That's why it is the only resin that is consistently successful in partial restorations. Because it molds accurately and retains its molded form in mouth service, no breakage, malocclusion or traumatization of ridges can be caused through warpage and distortion.

ast-metal-accuracy"
ull and partial cases.

No other resin approaches the "cast-metal-accuracy" of Densene "33," throughout processing and mouth service. It molds perfectly and *retains* its molded form.

Internal stresses which ordinarily cause warpage and distortion are *controlled* for release *during cure . . . before case is removed from flask!*

Obviously, it is the ideal denture material to safeguard the retentive resin-to-tissue fit of your full and partial dentures.



* One of the largest and most reputable laboratories in the country reported an average of only one remake for each 750 Densene "33" partial cases produced during the last year!

WHO'S WHO AND WHERE

Although we aim for accuracy in this index, last-minute changes often alter page numbers and positions

A. L. GARBER CO. ASHLAND, OHIO PRINTED IN U

GETZ-400

WG

FOR PRESSURE or NON-PRESSURE TECHNIQUES

The mix is thin and creamy enough so that you can take impressions without pressure.

This material is NOT STICKY. It wipes off easily with a towel.

Setting time is controlled (regardless of temperature at 4 minutes from start of the mix.

Allows 30 seconds to complete the mix for non-pressure technique. For tissue displacement, withhold the mix a few seconds longer.

Definitely does not crystalize, yet sets hard enough to eliminate change or distortion . . . safe to handle and wrap immediately.

Because this paste has resilient as well as resistant qualities, removed impression springs over undercuts and springs back again with accuracy.

Low in cost. 1 package (enough for 12 to 15 impressions), $3.00; Six packages, $2.70 ea.

FOR PARTIALS FULL DENTURES INDIRECT INLAYS

Dental Laboratories recommend it as the most accurate material on the market. It registers and holds the finest details.

No capsules or retardents to dissolve. It is ready to mix as it comes from the package.

It is not temperamental. Can be used with tap water the year around. No ice water required.

Tougher than hydrocolloids. Surfaces of models are hard as rock, smooth as glass.

Palatal bars go right to place because there is no sag or slump in taking high vault impressions.

Fully 15% more material per package. 10 oversize full-portion units and 4 half-portions. All half-portions if desired.

1 Box, $4.00; 3 Boxes, $3.75 ea.; 12 Boxes, $3.50 ea. 1 lb. Moisture-proof Glass Jar, $3.50; 12 jars, $3.15 ea.

Test these products without risk or cost. Order from your dealer on our money-back guarantee.

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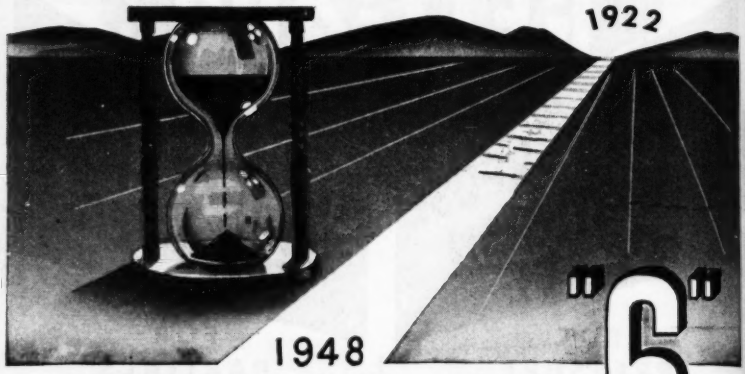

WILLIAMS 6

IT'S THE PROVEN "ALL-PURPOSE" CASTING GOLD

Williams first made "6" ALL-PURPOSE Casting Gold a quarter of a century ago. By keeping everlastingly at it they have made the good better and the better best so that today the original "6" is dentistry's most modern all-purpose casting gold — for any purpose, with any technique.

Make a check list of the qualities you would want in a casting gold. You will find them, every one of them, in Williams "6" with Indium: casts easily with remarkable precision; strong, springy, tough; not too hard for tooth enamel; beautiful light coin color. All this plus exceptional working properties. Try it.

ALLOYED INDUCTIVELY • UNIFORMLY SUPERIOR •

WILLIAMS Gold Refining Co., Inc.

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Healthy gingival circulation

IPANA + massage

Today, our soft fine diet and lax habits of mastication do little to promote healthy gingival circulation. Flaccid gum margins and tissue fissures, frequently encouraging gingival infection, may be the result.

IPANA plus massage has proved effective over many years in stimulating gingival circulation. You may confidently recommend this sound technique of oral hygiene.

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